Annual Progress and Services Report

FFY 2018

The **mission** of the Department of Children and Families is to work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency. Our **vision** is that every child in Florida thrives in a safe, stable, and permanent home, sustained by nurturing relationships and strong community connections.

June 30, 2017

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Florida's Child and Family Services
Annual Progress & Services Report
Federal Fiscal Year 2018

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INTRODUCTION

The mission of the Florida Department of Children and Families is to work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency.

The Department strives to create and support a highly skilled workforce committed to empowering people with complex and varied needs to achieve the best outcomes for themselves and their families. In collaboration with community stakeholders, the Department will continue to deliver world class and continuously improving service focused on providing the people we serve with the level and quality that we would demand and expect for our own families.

As embodied in Florida's Child Welfare Practice, the vision is rooted in a sound knowledge base and a practice approach that is safety-focused, family-centered, and trauma-informed. The vision is achieved by focusing on seven general professional practices that are operationalized by using methods, tools, and concepts that make up Florida's Practice Model. These practices are directed toward the major outcomes of safety, permanency, and child and family well-being.

As in all aspects of social services, particularly child welfare, an integrated and collaborative approach with multiple partners and stakeholders is essential.

This Annual Progress and Services Report is intended to report progress on Florida's work toward the three primary outcome goals of safety, permanency, and well-being, as defined in the Administration for Children and Families' Child and Family Services Review (CFSR) process.

The Department supervises the administration of programs that are federally funded, state directed, and locally operated. The Department of Children and Families is responsible for the supervision and coordination of programs in Florida funded under federal Titles IV-B, IV-E and XX of the Social Security Act (45 CFR 1357.15(e)(1) and (2)). Policy development, program implementation and monitoring of the child welfare system are the responsibility of the Office of Child Welfare.

The measures of progress, objectives, and strategies laid out in the Five Year Plan are based on a high-level statewide performance assessment and include a comprehensive approach to three primary goals:

Goal 1. Children involved in child welfare will have increased safety and expanded protection.

Goal 2: Children involved in child welfare will live with permanent and stable families, avoiding disruption and return to out-of-home placement.

Goal 3: Children involved in child welfare will have improved well-being (education, physical health, and behavioral health) and live with nurturing families.

Achieving the goals depends heavily on the coordination and integration of activities across the various partners involved in Florida's child welfare system. The Department of Children and Families' Office of Child Welfare plays a vital role in the development of policies and programs that implement and support the Department's mission. The child welfare system is administered and coordinated through highly collaborative relationships with other state and local agencies, Tribal representatives, foster/kinship caregivers, foster youth, community-based lead agencies, the judiciary, researchers, child advocates, Guardians ad Litem, the Legislature, and private foundations to maximize child safety, permanency, well-being, and families' opportunities for success.

CHAPTER I. Collaboration

Engagement, Collaboration, and Coordination

Florida's Department of Children and Families' Office of Child Welfare engages in a high degree of collaboration. In developing policies and administering programs, the Department collaborates on a regular basis with other state and local agencies, the Economic Self-Sufficiency (TANF and SNAP) Program Office, Tribal representatives, foster/kinship caregivers, foster youth, Community-based Care lead agencies, case managers, the judiciary, the Office of Court Improvement, sheriff's offices conducting child protective investigations, researchers, child advocates, Guardians ad Litem, the Department of Juvenile Justice, the Legislature, and private foundations. The Department of Children and Families (hereinafter referred to as "Department" or "DCF") internal program and operations offices collaborate across their specialties, such as mental health, substance abuse, and economic supports, to the benefit of Florida's children and families touched by the child welfare system. Collaborative activities occur in both an informal and structured format, i.e., meetings, conference calls and impromptu technical assistance.

Florida's service delivery system is unique in that the Department contracts for the delivery of the child welfare services through Community-based Care lead agencies (CBCs). Service delivery is coordinated through an administrative structure of six (6) geographic regions, aligned with Florida's 20 judicial circuits, serving all 67 counties. Within the six DCF regions, CBCs deliver foster care and related services as defined in Florida statute[1] under contract with the Department. Child protective investigation requirements are also defined in statute (Chapter 39, Florida Statutes). In several geographic areas, the duties of child protective investigation are performed under a grant by county sheriff's offices[2]. Children's Legal Services (CLS) continues to function as an internal "law firm" for child-focused advocacy in all areas; in some areas, this includes coordination with attorneys under contract from the State Attorney's Office or the Office of the Attorney General. The Department remains responsible for program oversight, operating the Abuse Hotline, conducting child protective investigations, and providing legal representation in court proceedings. This delivery structure has been stable for several years.

This structure also provides an excellent opportunity to tailor services that address the diverse needs of Florida's children, families and communities and fosters creativity and productivity of child welfare professionals. During the report period, many examples of collaborative efforts occurred and are discussed below.

- The Department's Regional offices along with each of the CBC lead agencies continue to collaborate with other state and local providers to coordinate efforts on mutual families.
- Extensive collaboration between the Department of Children and Families, the courts, Guardian ad Litem Program, and community agencies led to many innovative court processes that helped to facilitate timely permanency. The CBCs, local agencies, and external stakeholders provided input into this Annual Progress and Services Report.
- In addition to state level partners, communities have worked together with local governmental agencies, such as schools and housing, employment and law enforcement agencies, courts and

[1]Lead agency requirements contained in ss. 409.986 through 409.997, F.S.

[2] As per s.39.3065, Florida Statutes, the county sheriff offices in Pinellas, Broward, Manatee, and Pasco Counties perform child protective investigations. County sheriff offices in Hillsborough and Seminole Counties are also under a grant to perform child protective investigations.

Tribes, as well as private and nonprofit service or advocacy groups. Examples of interagency efforts in Florida included:

- Coordination of physical and behavioral health services that involved shared data;
- Collaboration and coordination with agencies responsible for services to the developmentally disabled and public education so child welfare client needs were being properly addressed;
- Alignment of services and supports when child welfare and juvenile justice issues overlapped; and
- Identification of resources for child care, employment, and other services under the responsibility of non-child welfare agencies.

Ongoing Collaboration

The Department continued to strengthen its tradition of collaboration throughout all aspects of child welfare. Some collaborative efforts are formal, even required by law; others are continual, occurring on a daily basis as field staff work to find the best means to help children and families. Below is a description of some of these collaborations, which occur at both state and local levels.

State level

One significant partnership is with the Executive Office of the Governor's Office of Adoption and Child Protection (OACP). The Office of Child Welfare provides ongoing technical assistance and supports during OACP's many activities, particularly development and implementation of the five-year plan for Child Abuse Prevention and Permanency. Several other agencies, including the Departments of Education, Health, Juvenile Justice and Law Enforcement and the Agency for Persons with Disabilities, are partners in this comprehensive approach. Department staff from the regions also participate on the Local Planning Teams that work in specific geographical areas under the guidance of OACP.

Another collaboration across state agencies is the Florida Children and Youth Cabinet. The Secretary of the Department of Children and Families is a member, along with the agency heads of the Department of Juvenile Justice, Agency for Health Care Administration, Agency for Persons with Disabilities, Department of Education, and Department of Health. Additional members include the executive leadership of the Statewide Guardian ad Litem Office, Governor's Office of Adoption and Child Protection, the Office of Early Learning, and other appointed representatives from various advocacy and specialized groups. The Cabinet's charge is to develop a strategic plan to promote collaboration, creativity, increased efficiency, information-sharing and improved service delivery between and within state agencies and organizations that administer child welfare services.

Other collaborative efforts include various individual or combinations of state agencies and other governmental organizations, such as:

- The Agency for Health Care Administration (AHCA), for such issues as the Health Care Oversight and Coordination Plan, Medicaid payments and managed care for children, and for psychotropic medication prescription data. Refer to Appendix C - Health Care Oversight and Coordination Plan.
- The Department of Juvenile Justice (DJJ) targeting coordination of services for youth who are involved with both the dependency system and the juvenile justice system.
- The Agency for Persons with Disabilities (APD) and the DJJ, regarding services for children served by more than one agency.

- The Department of Health (DOH) regarding services and various health issues for children involved with child welfare. The Children's Medical Services (CMS) Program in the Department of Health is a significant partner across the state. CMS develops, maintains, and coordinates the services of multidisciplinary Child Protection Teams (CPT) throughout Florida. The teams provide specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services.
- The Department of Education (DOE), working on educational issues for children and youth. The Department is participating in several workgroups and committees within the Department of Education, including the State Secondary Transition Interagency Committee for students with disabilities and the Project AWARE State Management Team for student mental health services. Additionally, Casey Family Programs met with the Department and helped determine appropriate benchmarks for improvement.
- Florida's Department of Revenue, Child Support Program has been a partner with the Department for many years to develop and align practices in support of children involved in the child welfare system. One such joint initiative underway during the report period involves development of an operating procedure, Support for Children in Out-of-Home Care, for use by child welfare professionals. Partners on this initiative include the Office of Court Improvement (OCI), Child Support Program, Children's Legal Services, CBC lead agency Chief Executive Officer, Revenue Management and the Office of Child Welfare. The Department continues to have a strong relationship with the court system, including partnering with OCI on various training activities, such as the annual Child Protection Summit.
- The Department and Florida's Department of Law Enforcement (FDLE) have been partners for over a decade. Since 2003, the Department has co-located a position in the FDLE Missing and Endangered Persons Information Clearing House to ensure that all children missing from the care and supervision of the state are properly reported as such with local and state law enforcement and the National Center for Missing and Exploited Children. The Department has processed approximately 8,581 missing child reports on an annual basis, with 56% of the missing children located within one day and 82% within 7 days.
- The other collaborative program areas within the Department with a mutual responsibility for children, families and caregivers involved in child welfare include Domestic Violence, Substance Abuse and Mental Health for child and adult issues, Economic Self-Sufficiency for Medicaid eligibility and various financial or public assistance topics, and Children's Legal Services for all child welfare legal matters.

Other efforts involve state-level advocacy or special population groups:

- The Ounce of Prevention Fund of Florida, which continues to be heavily involved with the Department's various prevention activities and programs, such as Healthy Families Florida.
- Florida Guardian ad Litem Program (GAL), which has continued to have a close working relationship at the state and local level with the Office of Child Welfare and Children's Legal Services. For instance, a conference focused on children with disabilities was co-hosted by GAL and the Department in May 2016. The next GAL Disabilities Summit is scheduled for May 2017.
- Tribal organizations for the Seminole and Miccosukee tribes, which have continued to work in concert with the Office of Child Welfare and the regions. For example, in Broward County, the CBC lead agency, ChildNet, has established a specialized unit to work with the tribes.

- Former foster youth, such as the Florida Youth SHINE (Striving High for INdependence and Empowerment) organization, and the Independent Living Services Advisory Council.
- The Florida Youth Leadership Program, which is a statewide program that focuses on building the leadership skills of youth involved with the dependency system who are selected for the program.
- The Child Welfare Advisory Council, formed by the new Sunshine Care Health Maintenance Organization for managed care of the child welfare population.
- Florida State Foster/Adoptive Parent Association, for training and other events for foster/ adoptive families, and relative and non-relative caregivers.
- The Florida Coalition for Children, long-term advocates for abused, neglected, or abandoned children; significant membership includes most of the Community-Based Care lead agencies and case management organizations.
- Florida's Office of Early Learning/Early Learning Coalitions, which coordinate provision of early education to at-risk children.
- Florida Coalition Against Domestic Violence, which provides leadership to domestic violence center programs and is engaged in the development and incorporation of policy and practice specific to families and children experiencing family violence. The Florida Coalition Against Domestic Violence in partnership with the Department has established co-located domestic violence advocates in select sites across the state.
- Children's Medical Services, which has partnered with the Department to develop collaborative and aligned policies within DCF and DOH for children in out-of-home care.
- In collaboration with the Florida Coalition for Children, the Department established the Crossover Youth Workgroup to assess the growing concerns surrounding services and supports available to youth dually involved with the child welfare and juvenile justice systems. The workgroup members included representation from the local Community-Based Care lead agencies, Case Management Organizations, Department of Juvenile Justice, Agency for Health Care Administration and Office of State Court Administration. In October 2015, the workgroup presented a summary of work and recommendations surrounding identified systemic barriers in serving this unique population of youth. Specific deliverables from this workgroup included the updating of the data-sharing agreement between the Department of Children and Families and Department of Juvenile Justice as well as improvements to the data-matching process for the monthly reporting of dually served youth.
- The Department continues to partner with the Department of Juvenile Justice to improve services and supports for youth dually served by both state agencies. In June 2016, a joint agency statewide forum was held with front line staff and key stakeholders, including the Secretaries for the Department of Juvenile Justice and Department of Children and Families. As a result of this forum, both state agencies developed a joint collaboration plan at the state and local level to address key issues, specifically policy improvements, cross jurisdiction communication, education of staff and stakeholders, funding and resource development, assessment and evaluation of youth and information-sharing.
- The Child Protection Summit also annually includes the William E. Gladstone Award, which honors a member of the judiciary who embodies the sentiment behind the late Judge Gladstone's enduring passion for more than three decades to create necessary and meaningful child welfare

improvements. The purpose of this award is to identify and celebrate the important work of judges and magistrates making the greatest contribution to the courts in serving dependent children and their families.

Collaboration for the Annual Progress and Services Report (APSR)

The statewide Child Welfare Practice Task Force, an interdisciplinary panel, includes representatives from a variety of stakeholder groups throughout Florida and is a collaborative partner for the APSR. The Child Welfare Practice Task Force includes representatives from the Office of State Courts Administrator - Court Improvement Program, Judiciary, Florida State University (FSU) School of Social Work, FSU Center for Prevention and Early Intervention, Department of Health, Guardian ad Litem Program, CBC lead agencies, State Attorney's Office, Children's Legal Services, Regions, and other partners.

The Department's Regions and the CBC agencies maintain strong and extensive networks of collaboration at the local level. Many of the relationships are common to all areas; for example, local law enforcement agencies are connected to child protective investigation activities, local school boards partner to ensure educational access and success, and local circuit and other courts work with Department, CBC, and CLS staff.

Local collaborative initiatives underway in DCF regions and the CBCs include:

Northwest Region:

The Northwest Region (NWR) is comprised of three circuits (1, 2 and 14), two CBC lead agencies and 16 counties in which child abuse investigations are conducted by the Department of Children and Families. Each circuit is unique and diverse in the population it serves. Circuits 1 and 2 are the most populated areas serving the most children and families. The NWR also works in collaboration with the Poarch Creek tribe from Alabama (a federally recognized tribe from Alabama with a reservation located close to the Florida - Alabama border).

The two Community-based Care Lead Agencies in the Northwest Region are FamiliesFirst Network and Big Bend Community-based Care.

Circuit 1

FamiliesFirst Network of Lakeview (FFN) represents a partnership with the Department of Children and Families (DCF) to provide an array of foster care and related services in coordination with network partners for four counties in Circuit 1. The network includes DCF, FFN - a Division of Lakeview Center which is an affiliate of Baptist Health Care, judiciary sub-contracted service providers, foster parents, the Community Alliance, agency stakeholders, and the community working together to implement the legislative mandate for community-based care. Services include case management for out-of-home and in-home placements; foster home recruitment, training, recommendation for licensure, and support; adoption support; independent living program; dependency court resource facilitation; sub-contract management; and other related services to abused and neglected children and their families.

The Circuit 1 Community Alliance now has four local alliances and one overall Alliance where data and information is shared across the Circuit.

A primary example of collaboration in Circuit 1 is the Early Childhood Court Project. The Early Childhood Court Project is a specialized dependency court program that focuses on children ages birth to three (3)

years of age started in Escambia county and has now expanded to Okaloosa County. The program addresses the needs of families who have come into the purview of the court system because they have abused or neglected their children. The program utilizes existing community resources to provide a coordinated and integrated approach to address the underlying issues of abuse and neglect while at the same time enhancing the parent-child relationship and improving permanency outcomes and the safety and well-being of the children enrolled in the program. The program is unique in that it intervenes at the family level rather than the individual family member level. Every member of the family is offered the services that they need to enhance family stability and child well-being.

The Escambia County Early Childhood Court Team consists of: Dependency Judges, CLS, Parent Attorneys, GAL, Court Administration, Dependency Court Resource Facilitator, Child Protective Investigators, Family Services Counselors, Community Mental Health, Substance Abuse and Domestic Violence treatment, agency service providers, Community Prevention and Early Intervention Providers, Early Learning Coalition (ELC), and Healthy Start.

Circuits 2 and 14

Big Bend Community-based Care (BBCBC) is the CBC Lead Agency for Circuit 2, Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla Counties and Circuit 14, Bay, Calhoun, Gulf, Holmes, Jackson and Washington Counties. BBCBC partners with local agencies to provide case management services to the children and families in the child welfare system and to assist children and families in managing difficult life events, monitor living situations and recommend abuse prevention services such as counseling, parent training and supervision.

BBCBC is committed to coordinating services with schools, colleges, universities and early learning coalitions that jointly serve children. Through Memorandums of Understanding and Interagency Agreements, BBCBC works collaboratively with each party to help define the working relationship, refine practices, improve communication and strategize ways to work more efficiently. BBCBC also develops collaborative projects such as Baby Court, Nurse Care Coordination and ABC Visitation.

BBCBC collaborates with multiple and diverse community organizations including DCF and the provider network to develop and manage a system of care that demonstrates quality programmatic and financial outcomes through coordination, transparency and efficiency. The system of care is based on a service delivery approach designed to create a broad, integrated process for meeting the service population's needs. Each partner brings diversity, advocacy, program expertise, experience and community standing to the System of Care. The approach to developing a network of care is grounded in collaboration and the coordination of services. However, it is understood that, as the Lead Agency, BBCBC is the single point of organizational accountability for developing and managing the system of care.

As a network-managing agency, BBCBC's primary role is to establish and maintain an integrated network of providers with the goal of ensuring optimal access to and the provision of quality services. BBCBC's approach to collaborative is inclusive of DCF, subcontracted services agencies, formal and informal providers, key community stakeholders and, the individuals, families and communities served.

BBCBC, as the steward of both child welfare and substance abuse and mental health dollars, is uniquely positioned to focus on the integration of child welfare and substance abuse and mental health services. Currently, BBCBC has initiated two pilot programs. One focuses on a macro approach to a treatment model in child welfare, the other a more micro approach. Both projects are moving forward in collaboration with Florida State University's College of Medicine. The macro project also partners with

Voices of Florida and is looking at the need to efficiently and systematically screen and assess parents of child-welfare involved children for behavioral health disorders. The more micro project is working to expand training to case managers and possibly develop a screening/assessment tool. These two projects are being managed by BBCBC's Director of Integration to ensure that the goal of integrating Substance Abuse and Mental Health and child welfare is not only an agency-wide focus but that these pilot projects can be replicated across the State.

BBCBC has also recently partnered with Florida State University Center for Integrated Behavioral Healthcare. Florida State University has contracted with subject matter experts to train the core portion of pre-service. Core focuses on the areas of family dynamics, behavioral health and family engagement as it relates to child maltreatment and neglect.

Quality Parenting workgroups are facilitated by the BBCBC Quality Parenting Initiative (QPI) specialist. The workgroups consist of multi-agency stakeholders in the foster care arena. Its purpose is to bring to the table problem solving ideas, innovative thinking and planning to address the various issues regarding recruitment and retention. As a direct result of the workgroups, BBCBC has contracted with the National Quality Parenting Consultant, Carole Shauffer, for assistance in designing and planning recruitment initiative increasing community awareness of the critical need for foster homes through faith-based and business-based community activities, implementing local policy changes to enhance foster home recruitment and retention efforts, creating sub committees to address areas of improvement and effectively changing policy to better meet the needs of recruitment and retention.

Both circuits have benefitted from the partnership formed on the workgroups by fostering a team approach to problem solving. Desired outcomes include improved relationships with systems partners and a reduction in communication challenges that often leads to foster parent dissatisfaction within our system of care.

Big Bend Community-based Care trainers will continue to train the Specialty Track of pre-service which is more specific to Dependency Case Management. Big Bend is very excited about the prospect of partnering with FSU as it allows Big Bend Trainers more time to develop an in-service library to enhance professional development of child welfare staff. It will also allow Big Bend trainers more opportunities to assist staff with more personal one on one consultations and help with BBCBCs goal to assist child welfare staff with the certification process and enhance professional development offering quality trainings.

Quarterly Caregiver Partnership meetings were initiated in 2016 as a forum for all substitute caregivers to have meaningful dialogue with local leadership about the issues that are most impactful to their roles within our system. This meeting affords caregivers the opportunity to ask questions, receive information, participate in training and provide support for each other. They are able to express concerns and gain knowledge from individuals within the system who can advocate for positive changes to be made on behalf of the children and families. Participants include both licensed and non-licensed caregivers, as well as leadership from within the system such as Children's Legal Services, Child Protective Investigations, Case Management Organizations and BBCBC.

BBCBC partners with DCF, Agency for Workforce Innovation, Office of Early Learning, Department of Education (DOE), Guardian Ad Litem (GAL), Department of Juvenile Justice (DJJ), Foster Parents, local school districts and local childcare providers for the Everybody's a Teacher initiative. Since its launch, BBCBC's Everybody's a Teacher campaign has been very successful in the identification of dependent children to local school districts, enhancing service provision. The goal is local ownership, with each individual plan listing the specific needs for each dependent child in the area. The plans include how to

identify dependent children in the school districts, increase access to educational services, improve communication of all parties and identify educational surrogates for all dependent children.

The Northwest Florida Regional Domestic Violence and Child Welfare Initiative includes the Florida Coalition Against Domestic Violence (FCADV), State of Florida Attorney General's Office, The Salvation Army Domestic Violence & Rape Crisis Program, the Florida Department of Children and Families, Big Bend Community-based Care, and local law enforcement. The mission: Communities working together to provide support, resources and services that strengthen families and keep homes safe from domestic violence and child abuse.

BBBCB has been an active member of the Early Childhood Mental Health System of Care grant for the past five years. In September of 2016, the grant entered a second phase, expanding the opportunities to better serve the community with service dollars. BBCBC is in negotiations with DCF to administer the service dollars within the counties covered by the grant. While both Bay/Washington and Leon/Gadsden have different initiatives, the four counties are working together to determine the best use of service dollars. Currently, the two sites are hoping to expand High Fidelity Wrap Around services as well as the developmental screening of young children (the Ages and States Questionnaire®:Social Emotional -ASQ-SE).

Northeast Region:

The Northeast Region (NER) is comprised of four circuits (3, 4, 7, and 8), five Community-Based Care (CBC) lead agencies, and 20 counties in which child abuse investigations are conducted by the Department of Children and Families. Each circuit is unique and diverse in the population it serves. Circuit 4 is the most populated area in the NE Region serving the most children and families.

The five CBC's consist of Partnership for Strong Families, Family Integrity Program, Family Support Services, Kids First of Florida and Community Partnership for Children. Collaboration in the NE Region occurs at various levels to include local and regional leadership teams. Teams consist of leadership and line staff, as well as prevention providers, Department of Juvenile Justice (DJJ), Child Protection Team (CPT), CBC lead agencies, and local Case Management Organizations. The monthly Barrier Breakers and Quarterly Partnership meetings are primary channels of collaboration, although there are also operations meetings. All have worked with the schools systems in their jurisdiction to improve communication and services for children involved in the child welfare system.

Circuits 3 & 8

Partnership for Strong Families (PSF) is the CBC lead agency for Circuit 3, Bradford, Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee and Taylor Counties and for Circuit 8, Alachua, Baker, Gilchrist, Levy and Union Counties.

Partnership for Strong Families (PSF) promotes the philosophy that everyone is a member of the Continuous Quality Assurance and Quality Improvement team, including stakeholders, families, children, caregivers, Partner Family Parents, PSF, the PSF Board of Directors and provider staff at all levels. Data is continuously gathered and analyzed and improvements are made to services and processes when compliance is not met or when safety/security issues arise. Information is shared in an effort to eliminate duplication and to increase collaboration and knowledge. All parties work together to identify and address areas in need of improvement, create action plans for improvement, monitor progress and make adjustments when the data indicates the changes have not had the desired impact. Information related

to performance, areas in need of improvement and evidence of success is shared to facilitate the Plan, Do, Check, Act protocols of continuous quality improvement.

PSF works collaboratively with the Board of Directors, DCF Administration (including Contract Management), sub-contracted Case Management Agencies, service providers and stakeholders (including but not limited to Courts, Guardian ad Litem, Children and Families, Partner Family Parents, Caregivers, Children's Legal Services, Department of Juvenile Justice and Children's Partnership Councils) to define the evidence of success; review and enhance quality management data collection and reporting system/process, and to review performance and institute changes at the system/process and case levels, to drive improvement. PSF, in partnership with the various stakeholders, strives to provide a well-established evidence and trauma informed system of care that assesses and serves the needs of the local communities and the children and families served.

PSF participates in the following additional collaborative forums:

- Managing Entity (ME) - Lutheran Services Florida (LSF) added PSF to their care coordination process to identify fragmentation of services for the most vulnerable populations. PSF is working to review the families who have cycled through the children welfare system to identify barriers to services and provide assistance if able. Through this process, gaps and needs are also discussed to improve the larger system. LSF has also been a great partner in resolving funding issues with community behavioral health providers, and recently agreed to fund a new position to enhance the skills of child welfare staff to engage and work with perpetrators of domestic violence.

- Students to Successful Citizens - PSF has joined the local Students to Successful Citizens community workgroup in looking at ways to decrease the number of youth arrests at school. The Alachua County System of Care was developed and implemented in July 2016. This includes a school-wide response to behavior and discipline through a trauma-informed lens, while also utilizing restorative justice principles. At the end of September 2016, 75 children across four elementary schools, two middle schools, and one high school, had been enrolled in services.

- Child Welfare/Domestic Violence Quarterly Leadership Team Meeting - This is a collaborative meeting between the five Domestic Violence Shelters serving PSF's 13 Counties, DCF and PSF. The meeting focuses on improving the response to Domestic Violence and looking at how we can create a unified shift in practice. In addition to this meeting, PSF has helped to re-establish a task force subcommittee, specific to child welfare, in Alachua County. This task force is led by the local domestic violence shelter, and has already started to serve as an opportunity for training and collaboration. Additionally, FCADV has offered assistance with training for the new position being implemented by PSF and LSF. This position will help front line staff develop the skill to better engage perpetrators and to work with them as parents.

- Children's Partnership Councils - In 2013, Partnership for Strong Families initiated Children's Partnership Councils, groups of community leaders, child welfare professionals and frontline workers, in five regional communities. These Councils have representation from more than 20 community and state agencies including law enforcement, Department of Children and Families, case management agencies, managing entities, United Way, Kiwanis Club, faith-based organizations, Guardian ad Litem, Department of Juvenile Justice, Department of Corrections, Healthy Families, school departments, mental health providers, Department of Health, business representatives, workforce boards, Early Learning Coalitions, the University of Florida, public

libraries, Substance Abuse Prevention Coalitions and other community non-profits. These committed council members meet together in their respective communities on a bi-monthly to quarterly basis to seek out opportunities for collaboration to fill service gaps. Each Council also has a small budget to strengthen prevention efforts in their respective counties. So far, Councils have voted to allocate money toward safe sleep environments, individual rent/utility assistance for families in crisis and support for youth identified as homeless. In the 2016-2017 fiscal year, Councils have also allocated funds to purchase bus passes for families to attend medical and counseling appointments, emergency recovery items for families affected by Hurricane Hermine, vouchers for GED exams and child and infant safety products including cabinet locks. The Children's Partnership Councils continue to grow and make plans to meet their council goals and priorities.

- Child Welfare/Domestic Violence Quarterly Leadership Team Meeting - This is a collaborative meeting between the five Domestic Violence Shelters serving PSF's 13 Counties, DCF and PSF. The meeting focuses on improving the response to Domestic Violence and looking at creating a unified shift in practice.

- Human Trafficking Review Team - PSF created the Human Trafficking Review Team in collaboration with Department of Juvenile Justice and Department of Children and Families along with community agencies who also serve this population including Law Enforcement, Medical, Clinical and other community agencies. The team is a multidisciplinary team that has some expertise or experience working with the child victims of human trafficking; the team focus is on information sharing between agencies and well as assessment and planning for identified youth. The team also identifies gaps in services or barriers to services that the team or multi-agency collaboration can work together to solve. The team assists with determination of children who meet Safe Harbor criteria and placement recommendations. The team reviews safety, well-being and permanency for children who are the victim of human trafficking. PSF collaborated with Lutheran Family Services to plan for a Human Trafficking Symposium to be held January 2017 in an effort to establish a Human Trafficking Coalition for Circuit 3.

- Staff Development - Partnership for Strong Families is committed to partnering with all members of the community including those that do not specifically work with children and families. For example, PSF invites representatives from local banks, health and fitness centers, automobile dealerships, and crime prevention organizations to offer workshops and information sessions. PSF also hosted Center for Autism and other Related Disabilities including POPIN to hold lunch and learn sessions at Partnership. These sessions are open to the public as well as to our employees. Additionally, we have partnered with Alachua County School Board Extended Day Program (EDEP), Catholic Charities, Girls Place and other private foundations to provide training such in Trauma Informed Cared and Compassion Fatigue and Myers Briggs.

Circuit 4

Family Support Services of North Florida (FSSNF) is the CBC lead agency for Circuit 4, Duval and Nassau Counties. Kids First of Florida (KFF) is the CBC lead agency for Circuit 4, Clay County.

Family Support Services of North Florida (FSSNF) collaborates and partners with community partners and providers. Memorandum of Understandings (MOUs) have been implemented with local school systems that allow the sharing of all academic records for students in care. FSSNF has developed multiple

resources to address education needs at every stage of a child's development, from early intervention preschool classes to innovative alternative education opportunities for teens. FSSNF has built a comprehensive approach that ensures each child receives the services he or she needs for academic success.

The FSSNF Education Liaison maintains educational information on every school-aged child, performing routine data matches to ensure every child is enrolled and attending school. MOUs with the Nassau County School Board (NCSB) allows direct data sharing for real time education information for the clients we serve. The Education Liaison's complete educational reviews and closely monitors grades to determine whether a student needs additional ancillary services. The liaison also trains and assists with recruitment of educational surrogates for youth who are in need of this support. FSSNF has consistently made efforts to improve the education outcomes for youth ages 18-23, specifically youth earning a high school diploma or GED. Through a partnership with the City of Jacksonville through the Public Service Grant (PSG), a post-secondary support coordinator has been added to the team to address schooling issues for this population. Tutors are engaged for all students who agree to work with this resource for additional supports to improve their skills and promote further education. This position has had a significant positive impact on the relationship with Florida State College of Jacksonville (FSCJ) through their new Student Support Coordinator positons. These positions are focused solely on young adults who have been in, or aged out of, the foster care system. They make tracking progress and have really added a new dynamic to the growing partnership between FSSNF and FSCJ.

FSSNF has a Service Agreement with Community-based Care Integrated Health (CBCIH) which serves as the liaison and integrator of medical, dental and behavioral healthcare for children in care under the Medicaid Child Welfare Specialty Plan with Sunshine Health. In turn, CBCIH has partnered with Sunshine Health to provide statewide care coordination for our children in care for the health plan.

FSSNF participates in collaboration with DCF, Agency for Persons with Disabilities (APD), and DJJ on a monthly Champion Call to review children with special needs for APD placement and children that are in DJJ commitment programs to ensure effective transition back to the community.

FSSNF's Behavioral Health Care Coordinator (BHCC) works closely with Sunshine Health and is responsible for monitoring children in need of special mental health and substance abuse services such as STFC, STGH, SIPP, BHOS, TCM and In-Home Services. In addition, the BHCC manages the suitability assessment process for child who may need a higher level of care and lead's the multi-disciplinary team in determining the most appropriate services needed.

FSSNF has been on the forefront of leveraging the court system to improve outcomes for children. This is done through strong relationships within the local judicial systems and through the Model Court Initiative, an evidence-based practice which has strengthened collaboration with local child welfare partners. The Model Court is one (1) judge to hear both dependency and delinquency cases and a General Magistrate who oversee the Independent Living/Extended Foster Care court docket, thereby ensuring continuity in the coordination of services to the child, especially as it relates to his or her education and service needs.

Girls Court was a collaborative effort between Judge David M. Gooding, the Delores Barr Weaver Policy Center, FSSNF, the Department of Juvenile Justice, the State Attorney's Office and the Public Defender's Office. In 2016, Girls Court went through a redesign and plans for the program to start up again in 2017 focusing on a younger population with more parental involvement. Girls Court is a specialized form of juvenile court linking at-risk girls to community resources, social service agencies, and mentors, while offering each girl a holistic team approach in order to reduce recidivism, detention, and commitment

programs among girls. Girls Court provides girls and young women a team of professionals to help develop trust and empowerment, with a focus on providing individualized services to prevent further involvement in the justice system. Girls Court gives girls a voice in the courtroom, help them feel more connected and ultimately have a higher chance of success in completion of probation. The voluntary Girls Court also connect them with needed services and aims to prevent teen girls from entering into the dependency system as parents. The current focus is on teen mothers, pregnant teens and human trafficking victims.

The Fourth Judicial Circuit Court in Duval County continued Safe Baby Court also known as Early Childhood Court (ECC) that was started in October 2015. The Community Court Coordinator position to leads this program. Safe Baby Court is a specialized court program for open dependency children from the zero to three population. The goal of Safe Baby Court is to expedite permanency and educate the community about the maltreatment amongst our most vulnerable population. Families that participate in the voluntary program have monthly court hearings, monthly family team meetings, enrichment activities and an extra layer of support and guidance. Each case is examined to find and correct any deficiencies. It is also examined to ensure that the children in the case are receiving all services in order to encourage their healthy growth and development. Safe Baby Court clients can participate in specialized therapeutic programs such as Child Parent Psychotherapy and Circle of Security. Child Parent Psychotherapy is a treatment for trauma-exposed children ages 0-5. CPP focuses on how the trauma and the caregiver's relational history affects the caregiver-child relationship and the child's developmental trajectory. Circle of Security is a relationship based early intervention program designed to enhance the attachment security between parents and children. ECC has served 26 children, reunified five families, had one adoption, and one case closed out to Permanent Guardianship. ECC is continuing to see growth and success. ECC has state and national support through the Zero to Three Institute. Zero to Three provides state bi-weekly calls as well as weekly national calls to support all the community court coordinators. These calls provide networking opportunities as well as training.

The Safe Babies Task Force continues to bring community partners together to promote the safe and healthy developmental needs of the 0-3 years of age population who are involved in the child welfare system. The courts continue to utilize the Safe Babies court report to be informed of services provided to the child and family during quarterly court proceedings. Community resources and identified gaps are discussed in quarterly meetings. Trainings have also been provided to promote the safety, well-being and understanding of this vulnerable population. Dr. Neil Boris and Dr. Amy Dickson provided a three-hour training July 20, 2016 to bring awareness of the importance of early intervention and improving the outcomes for infants and toddlers.

The Family Preservation Department collaborates with traditional child welfare stakeholders, but also forged strong partnerships with groups such as local shelters, community center, faith-based organizations, and early learning programs. Family Support Services also has STEPS workers co-located in the local elementary schools to weave together a stronger network of support.

FSSNF collaborated with DJJ to implement the Crossover Youth Model developed by Georgetown University to address the needs of children who are in both the child welfare and DJJ systems. Each crossover youth is required to have a multi-disciplinary team (MDT) staffing within 10 days of arrest. The State Attorney's Office and the Public Defender attend by conference call. JPO, IDDS, and School Board Representative also attend. Any other people that play a role in the child's life (foster parent, GAL, etc.) are invited and encouraged to attend.

FSSNF is actively involved in Jacksonville's System of Care Initiative (JSOCI), funded by a planning grant from the Substance Abuse & Mental Health Services Administration (SAMHA) is working to transform Jacksonville's mental health services into a coordinated system of care to better meet the needs of youth with serious emotional disturbances and the related needs of their families. The grant funds wraparound services to children and families that are involved in multiple systems-DJJ, foster care, homeless youth, early learning programs and childcare. The wraparound coordinator works with child welfare case managers to ensure all positive natural supports are identified and developed.

FSSNF is a strong component of youth advocacy. One of FSSNF staff members is a past president of Florida Youth Shine. Florida Youth Shine (FYS) is a youth-run, youth-driven organization open to teens and young adults between the ages of 13 and 24 who were ever in Florida's child welfare system. FYS was created as a mechanism to include the voices of foster and former foster children in forums where decisions about child welfare are made. Members consulted with DCF on the Independent Living Re-Design bill prior to it entering legislative session and continued to advocate for the bill as it went through the legislative session. Members have participated in training child welfare staff on "The Trauma of Removal." Members advocate for current children in foster care by facilitating workshops in leadership seminars for teens. FSSNF is now developing a program with the Magellan youth advocacy group My Life. This is a program provides local, state and national opportunities for youth to advocate for issues related to foster care, substance abuse, mental health and the juvenile justice system.

FSSNF, in collaboration with community partners, creates and implements enrichment activities for teens such as: SPLASH = SCUBA Promotes Life Goals and Supports Healthy living. Participants received their SCUBA certification on a diving trip to the Keys. This program is accomplished in partnership with FL State Parks, YMCA, Scuba Lessons Jax, the University of Miami and the Professional Association of Diving Instructors. Another enrichment program is Tour de TRAILS = 50-mile bicycle riding challenge on an established bike trail; youth received a high-end crossover bicycle and gear. This program is accomplished in partnership with the YMCA, JSO, and Open Road Bicycles (San Marco). Two other enrichment programs focus on the development of more traditional skills.

FSSNF's Passport to Leadership is a 6-month program concentrating on leadership, employment, community volunteerism and education planning. This program is accomplished through partnerships with Disney's Epcot, Vistakon, City of Jacksonville, Work Source and other community partners. "The Challenge" is the newest program to Family Support Services, created in 2015, to put youth outside of their comfort zone to force them to rely on their peers to accomplish goals. Young people who participate in this program are taking part in activities that will have them learn new skills "by accident". This exciting new program is possible through partnerships with University of North Florida (UNF), The Edge Rock Wall, Yoga 4 Change, In the Breeze Ranch, FL State Parks and Hillsborough County Parks and Recreation. Volunteerism has been incorporated into all Independent Living programs through partnerships with Habijax, Clara White Mission, Humane Society and Jacksonville Beach so the young people are exposed to the value of giving back.

Kids First of Florida (KFF), collaborates with the following major partners: Guardian Ad litem (GAL) program, Clay County School Board, Quigley House (domestic violence service provider), Clay County Court, DCF, CLS, CBHC and Children's Home Society. KFF has had several Lunch and Learns with these partner agencies and has provided trainings and basic overviews of the practice model to them. Most of these agencies participate in on-going Clay County Implementation meetings to discuss the practice model and how it is working. Barrier Breaking meetings include DCF and KFF administration, and other community partners. Potential barriers within the system of care are identified and addressed for

solution. KFF management and supervisors meet with CLS attorneys and the supervising and managing attorneys to discuss what's working well and things that need improvement in the legal realm. Quarterly meetings are held between KFF, DCF and CBHC supervisors and managers providing an opportunity to discuss what is going well and where improvements can be made.

KFF has a good relationship with many of the local churches which has resulted in donations of Christmas gifts, backpacks, suitcases, and Packs of Hope for children in care. The churches have also allowed KFF to use their rooms for meetings and trainings. A local hospital provided backpacks and Easter Baskets for the children.

KFF and DCF Management meet with the Clay County Sherriff to discuss roles in the community and working relationships. KFF is also active in the local meetings to include its partner agencies, such as the Mercy Network, Community Alliance and the Clay Action Coalition.

Circuit 7

Circuit 7 has two CBC lead agencies. Community Partnership for Children is the CBC lead agency for Flagler, Putnam and Volusia Counties. Family Integrity Program serves as the lead agency for St. Johns County and is operated by the St. Johns County Board of County Commissioners, a local governmental agency.

Community Partnership for Children (CPC) has a collaborative network of service providers, community partners and stakeholders. Our partnerships include but are not limited to: Department of Children and Families, Agency for Persons with Disabilities (APD), Children's Medical Services (CMS), Department of Juvenile Justice (DJJ), Halifax Behavioral Services, Volusia, Flagler and Putnam Health Departments, Volusia, Flagler and Putnam County School Boards, Guardian Ad Litem, Children's Home Society, Devereux of Florida, Florida United Methodist Children's Home, Neighbor to Family, Domestic Abuse Council, Stewart Marchman Center, Healthy Families and Early Learning Coalition. CPC also maintains relationships with faith-based organizations to assist with the recruitment of foster parents and adoptive parents.

Family Integrity Program (FIP) has worked in partnership with local service providers, state, and federal entities to best serve the local needs of clients. As such, FIP understands the importance of strong community collaboration and quality communication to meet local initiatives and statewide interagency and working agreements. Local ongoing management is necessary to ensure the fidelity of the agreements and provide for reciprocal feedback regarding successes and challenges. Examples of such collaboration include, but are not limited to:

- The regular review or staffing of complex cases with the Agency for Persons with Disabilities (APD);
- FIP's partners with Children's Medical Services (CMS) and Children's Home Society to recruit local medical foster homes;
- Interfaces with the Department of Juvenile Justice (DJJ) through a unified court system to best serve crossover youth; participation in Juvenile Justice Council for St Johns County;
- Collaborating with the Agency for Health Care Administration (AHCA) and CBCIH to meet the mental health needs of the children in our care;
- Monthly meetings with St. Johns County Sheriff's Office and Child Protection Team to discuss cases with an ongoing criminal investigation;

- Partnering with St. Johns County Housing and Community Development as well as Social Services to assist clients;
- Partnering with the local domestic violence shelter as well as the local mental health and substance abuse providers- co-located staff with DCF Investigations and FIP Case Management;
- Participation on the Circuit 7 Community Alliance;
- Monthly meetings with Judge, School Board Homeless Liaison staff to address unaccompanied youth;
- Monthly Behavioral Health Consortium that is composed of other community resources/leaders.

In addition to the above stakeholders, FIP has formed informal relationships with the faith- based community, which serves as a major support to many of the clients served. FIP continues to be a presence in the community through these informal support networks. Monthly meetings, referred to as Integrated Services Team meetings are held with community stakeholders, including the stakeholders referenced above, to share ideas and services amongst the service providers.

The Health and Human Services Advisory Council is currently initiating a Community Needs Assessment. This Assessment completed in conjunction with the St. Johns County Behavioral Health Consortium, Continuum of Care, Flagler Hospital and St. Johns County Health Department.

Central Region:

The Central Region (CR) is comprised of four circuits, four Community-based Care (CBC) lead agencies, one sheriff's office that conducts child abuse investigations and 11 other counties where child abuse investigations are conducted by the Department of Children and Families. Each circuit is unique and diverse in the population it serves. Circuit 9 is the most populated area serving the most children and families, and all child abuse investigations are completed by the Department.

Circuit 5

Kids Central, Inc. (KCI) is the Community-based Care Lead Agency for Circuit 5 serving Citrus, Hernando, Lake, Marion and Sumter Counties. The KCI current community-based care model of care represents a comprehensive redesign of the state's child welfare system, which allows for increased local control, accountability and flexibility to better serve the communities in Circuit 5. To accomplish this objective, Kids Central has developed strong relationships and collaborations with a variety of local agencies to provide a comprehensive range of services including: prevention, diversion, case management, in-home and out-of-home care, foster care, family reunification, adoption, Independent Living Services, Kinship Care services, Healthy Start, and community engagement.

The Department, Kids Central Incorporated, Youth and Family Alternatives, Children's Home Society, The Centers, and CLS participated in an Out of Home Care Project in response to the high shelter rates over the last two years (2015-2016) in Circuit 5. The group broke down into pairs, each pair from a different discipline, to review cases for prior services, removals, prior investigations, etc. Although there was no one cause found, the group did come up with several areas that could be improved to possibly reduce the shelter rate. Over the last several months the Circuit has seen a decrease in shelters and the exits of children leaving out-of-home care has exceeded those entering care. The Department and Kids Central continue to meet regular to monitor and assess the effectiveness of the strategies implemented.

Circuits 9 and 18

Community-based Care of Central Florida (CBCCF) is the Lead Agency serving Orange, Osceola and Seminole Counties in Circuits 9 and 18. Major stakeholders of the Department, CBCCF and the Seminole County Sheriff's Office include youth, parents (biological and adoptive), caregivers (relative and foster), Judiciary, Guardian Ad Litem, and case management provider organizations. Extended stakeholders include local provider/child serving organizations, local government and law enforcement. Working agreements/Memorandums of Understanding are in place for most entities that are essential for serving children/families involved in the child welfare system of care.

Children, Young Adults, Parents & Caregivers, Department of Children & Families, Case Management Agency Partners include Children's Home Society, Devereux, One Hope United, and Gulf Coast Jewish Family & Community Services, Seminole County Sheriff's Office Protective Investigations, CBCCF Board of Directors and Advisory County and Provider Boards, Domestic Violence Centers, Federation for Families, Youth Advisory Board, Guardian Ad Litem, Attorney Ad Litem, Children's Legal Services, SAMH, CFCHS, School Boards, Agency for Persons with Disabilities, Department of Juvenile Justice, Child Advocacy Centers, other CBC Lead Agencies, local law enforcement, Foster Parent Associations, Public Health Unit, Public Allies, and United Way, etc.

Circuit 10

Heartland for Children is the lead agency serving Circuit 10 encompassing Hardee, Highlands and Polk Counties. The guiding principles set forth by the legislature created an increase in local community ownership and a community voice in how services would be designed and delivered. HFC strongly believes that success in providing services for children involves fully engaging the local community. As a result, the past 10 years has seen the development of solid community partnerships, the fostering of connections to a variety of stakeholders including but not limited to:

- the courts
- social services providers
- businesses
- neighborhoods
- schools
- faith-based community

HFC maintains visibility and presence through participation in numerous community meetings and forums, community outreach events and brand development. Participation in these work groups, task forces and forums promotes cross system /cross program collaboration and integration. For example, HFC participates or has participated in, the Children's Services Council of Highlands County, the Polk Safe Haven Coalition, the Polk Vision Quality of Life Task Force, Polk Vision, Building a Healthier Polk Initiative, the Healthy Start Coalition, the Trauma Informed Coordinating Council, the Polk County Domestic Violence Task Force and the Bartow, Lakeland and Highlands County Chambers of Commerce, Safe Kids Coalition, Drug Free Highlands, and the Circuit 10 Human Trafficking Taskforce. Participation in these various groups allows HFC to solidify relationships with community stakeholders, receive ongoing input on the system of care's responsiveness, exchange information, continuously educate others about our system of care, and integrate services and programs. One example of the cross system/program

collaboration would be the commitment of the Children's Services Council of Highlands County to recruit an additional 25 foster families.

Additionally, HFC strengthens its presence in the community by participating in community events such as the United Way Back to School Bash, Polk County Family Week, Highlands County Family Week, YMCA Healthy Kids events, Pinwheels in the Park and the Junior League of Winter Haven's family day events.

HFC has demonstrated a history of utilizing a variety of methods to conduct ongoing assessment of our system of care's responsiveness in meeting the needs of children, youth and families. These assessments include both the roles that HFC employees fulfill as well as those of contracted service providers and stakeholders. HFC values and acts upon the input we regularly receive through our extensive collection of surveys. These surveys include: foster parent surveys, relative caregiver surveys, stakeholder surveys (includes CPIs, CLS, GAL, Courts, service providers and other related community organizations), youth exit interviews, Placement Quality Assurance calls (gathers input about the process of the child being placed and additional needs), Placement survey tool (for CPIs and Dependency Case Managers), and the HFC employee survey. These items are utilized to provide assessment of our system and stakeholders' effectiveness in addition to data gathered through our Quality Service Reviews, file reviews, contract performance measures and scorecard measures.

HFC has an extensive portfolio of interagency/working agreements that have been executed at different points over the life of the agency. HFC is currently a party to more than thirty (30) working agreements. HFC has robust stakeholder integration in our system of care.

Below are examples of some community partnerships developed by HFC either through the identified formal agreements or through informal, but valuable, relationships. HFC has taken the lead to create community-based solutions for serving our population.

- For the past five years Heartland for Children has worked in cooperation with Deana's Educational Theater out of Massachusetts to bring the Yellow Dress Production to High Schools in Hardee, Highlands and Polk Counties. The Yellow Dress is a dramatic one woman play based on the stories of young women who were victims of domestic violence. The carefully constructed program stimulates thought provoking discussion about relationships, a topic important to every young person's life. Audience participants will gain an understanding about how gradual changes in behavior can impact lives forever.

- HFC has developed interagency agreements with all local school districts and early learning coalitions in Circuit 10 that mirror the 2009 Statewide Interagency Agreement to Coordinate Services for Children Served by the Florida Child Welfare System. HFC has strong, open relationships with other agencies/ organizations that furnish educational and vocational services and supports for children in the child welfare system. The coordination of services and supports across these agencies is critical to positive educational outcomes for children. HFC has a dedicated Education Specialist who serves as a point of contact between the school systems and HFC. HFC partners with the local school districts to support better communication regarding individual child educational issues through the use of a school liaison model. Each local charter and public school identifies a child welfare liaison, usually a guidance counselor, to represent their particular school. The school liaison model has been in place since the 2008-2009 school year. These school liaisons attend annual training provided by HFC that includes child abuse identification and reporting, local child welfare system structure, and system updates. Although child abuse identification and reporting training from the command center will be online for

school personnel this year, HFC will continue to work with DCF and the school systems to provide training topics that keep children safe and that help get children connected to needed resources that will improve educational outcomes.

- HFC is currently finalizing working agreements with all of the local school systems to enable more efficient data sharing between the school system and the child welfare system. After ensuring legal compliance with the Family Educational Rights and Privacy Act (FERPA), HFC has been able to craft an agreement between the Polk County Schools and Heartland for Children. Those efforts resulted in data sharing via a secure Data Analytics Vendor (Mindshare) site that provides Case Managers with school information about their children, and provides selected school personnel with information that is vital to their ability to identify and support children. Grades, attendance and school information are provided to the Case Manager. This process is expected to be replicated in the Highlands and Hardee counties with each school district providing information as available from their data systems.

- HFC, along with the Department, the USF Department of Pediatrics, Children's Home Society Child Protection Team (CPT), Infants & Young Children of West Central Florida and the Department of Health Children's Medical Services, has a working agreement with USF Early Steps. The purpose of this agreement is to ensure that children under the age of three who are involved in substantiated cases of child abuse or neglect are referred for early intervention services as appropriate. The agreement outlines referral procedures and information sharing provisions for Early Steps Intervention services as outlined in the Individuals with Disabilities Education Act (IDEA).

- HFC has dedicated resources to participate in regional, local and community level task forces and has taken the lead on developing, acquiring and managing specialized services for minor victims of commercial exploitation. This includes the training of HFC staff and community stakeholders in the identification of human trafficking and sexual exploitation victims. HFC has been a principal contributor to the development of the Circuit 10 Human Trafficking Emergency Response Protocol. HFC identified and/or developed relationships with medical, substance abuse and mental health resources, as well as residential resources for minor victims of commercial exploitation. HFC is committed to ensuring that the child's emotional and physical well-being take precedence, and above all else, that the child should be approached from a trauma sensitive perspective.

- HFC identified points of contact within the agency to actively serve on the Polk, Highlands, and Hardee County Human Trafficking Task Force. HFC monitors the runaway activities of youth in care and facilitates specialized staffings for youth with high numbers of runaway incidents. One of the purposes of these staffings is to ascertain if there are indicators that the child may be a victim of human or commercial sexual exploitation. As a result of HFC's efforts to provide resources and to participate in community task force activities, HFC has observed an increase in communication and coordination of efforts regarding minor victims.

- There are 12 distinct law enforcement agencies in Circuit 10. HFC has strong working relationships with these agencies both at the leadership level and with front line staff, and we

either have a formal working agreement with each agency or that agreement is under development.

HFC has a strong working relationship with CLS, which has always been willing to collaboratively solve problems. In response to requests from CLS to coordinate a project with our CMOs to improve the quality of court documents, the Heartland Legal Workgroup, established in August of 2012, continues to meet every other month. It has become apparent that a coordinating body of representatives from CLS, Case Management Organizations and Heartland provides a collective systemic voice and conduit for the complexities of dependency court issues.

Circuit 18

Brevard Family Partnership (BFP) is the provider of foster care and related services in Circuit 18, Brevard County. The Leadership Roundtable is the Community Alliance for Brevard County, as established in 20.19 (6), F.S. The Leadership Roundtable tasked Together in Partnership (TIP) with the development of the service philosophy and approach for Brevard County. In addition, TIP established best practice standards, service philosophy, created an emergency response model and conducted a comprehensive analysis of the service delivery network currently in place in Brevard County. The recommendations of TIP were approved and accepted by the Leadership Roundtable. Brevard Family Partnership has and will continue to integrate the planning, assessment and community outcome goals as determined by the Leadership Roundtable throughout the development of the system of care and throughout the ongoing Quality Assurance (QA) process.

The Brevard Family Partnership QA process is agency and system-wide and involves staff and stakeholder groups across Brevard Family Partnership organizational units and across the community. All phases of Continuous Quality Improvement (CQI) emphasize participation, communication, and cooperation. The participation of stakeholders is fundamental to a well-designed and implemented CQI process. Stakeholders include:

- Children and families served;
- Staff members
- Board members
- Contract Providers
- Leadership Roundtable
- Together in Partnership (TIP)
- Department of Children and Families (DCF)

With non-Brevard Family Partnership personnel, Brevard Family Partnership uses focus groups and/or task-oriented work groups to engage stakeholders in the ongoing CQI process. These include:

- Performance Reviews Team
- Provider Network

Brevard Family Partnership uses surveys and may utilize public hearings, planning groups, etc. to gain broad, meaningful and ongoing stakeholder involvement if deemed necessary. Major stakeholders include the Department of Children and Families, Children's Home Society, Devereux Florida, Impower, Crosswinds youth Services, DJJ, and the Guardian ad Litem Program. Human service agencies throughout

Brevard County, along with Brevard Public Schools, States Attorney's Office, DJJ, United Way, and County Government are members of Together in Partnership. Together in Partnership is a committee staffed by Brevard County Government that meets for the purpose of information sharing and finding solutions to issues that arise in the human services areas. Sub-committees include child substance abuse and family management.

Brevard Family Partnership is a pilot Youth Thrive site. BFP supports and helps coordinate a Youth Advisory Council which is comprised of youth in out of home care and young adults who have exited foster care and continue to receive services. Members of the Youth Advisory Council are advocates in the community, and to our state legislators. BFP implemented Quality Parenting Initiative (QPI) and integrated foster parents into training and the system of care. BFP contracts with the Woman's Center, a local domestic violence service agency to have professional staff out posted in care centers with members of case management. These professionals provide technical assessment and resources to families served within the system of care. BFP also contracts with Aspire to provide substance abuse professionals who will be out posted with case management. Aspire provides technical assistance, assessments and service referrals to families in need of their services.

SunCoast Region

The SunCoast Region (SCR) is comprised of three Community-based Care (CBC) lead agencies, four sheriff's offices that conduct child abuse investigations and seven other counties where child abuse investigations are conducted by the Department of Children and Families. Each circuit is unique and diverse in the population it serves. Circuits 6 and 13 are the most populated areas serving the most children and families, and all child abuse investigations are completed by the local sheriff's offices. Circuit 12 investigations are divided between the Department and the Manatee County Sheriff's Office, while in Circuit 20 all child abuse investigations are completed by DCF. Circuit 20 is also the most diverse in population having both urban and rural communities. The SCR also works in collaboration with the Seminole tribe in Collier, Glades, Hendry, and Hillsborough counties.

The areas in the region with Department led investigations have ongoing collaboration with multiple community partners and stakeholders. The Department participates in performance data calls, family safety alliances in multiple counties, safe sleep coalitions, drug endangered children alliances, meetings with domestic violence partners and substance exposed newborn initiatives. There are behavioral health and domestic violence advocates co-located in the CPI offices who are available for staff to utilize their expertise. Finally, the Department is committed to the Substance Abuse and Mental Health Integration project in all Circuits.

Circuits 6 and 13

Eckerd Community Alternatives (ECA) provides case management services in Circuits 6 and 13. Circuit 6 covers Pasco and Pinellas Counties, and Circuit 13 serves Hillsborough County. ECA's system of care is strength-based, providing for individualized, culturally appropriate, child and family services. The system of care includes features that will strengthen and maintain family relationships and enhance community capacity building.

At Eckerd, building an effective and sustainable system of care is accomplished by creating an environment that supports change, develops connectivity and conveys information to all stakeholders.

Collaboration is achieved through frequent and transparent communication through the following venues:

- The Weekly Data Report is disseminated to multiple stakeholders in an effort to keep them engaged in the progress of the local child welfare agency. Weekly Performance Improvement Calls are initiated and facilitated by ECA every Monday morning and includes representation from its subcontracted Case Management Organizations (hereafter referred to as CMO), Child Protective Investigations (CPI), Department of Children and Families (DCF) contract management, Guardian Ad-Litem Program, Juvenile Welfare Board or Children's Board, as well as a host of other key stakeholders.
- Monthly All Management Meetings serve as an opportunity for management staff to network, team build and increase their skill set. In addition, supervisors are provided a forum to address systemic issues and policy interpretation, share best practices, develop improved processes, recommend change and work together towards common goals.
- Biweekly Program Director's meetings bring key executive management level staff together to collaborate and discuss case management processes, requirements, issues, performance, fiscal benchmarks and other identified issues. It is an opportunity to share best practices, complete data analysis, and provides a forum to maintain a systems perspective in a Community-based Care environment.
- Monthly Community Alliance Meetings are held in all three counties we serve and provide an opportunity to report progress on the programmatic and financial status of the Community-based Care lead agency. The Alliance consists of providers, child serving agency community leaders, and representatives of the judicial branch.
- Stakeholder/ Provider Workgroup meetings are held quarterly to bring together agencies that have contracts with ECA along with stakeholders in the community. This meeting is used to communicate, discuss monitoring processes, review contract requirements and exchange best practices.
- The Foster/Adoptive Task Force Meetings brings Foster Parent Association leaders together with ECA lead agency management staff, CMO management staff, and others collaboratively identified to assist with the foster parent program. Meetings are used for educational topics, distribution of foster parent resources, and dialogue between case management staff and foster parents.

ECA's website www.eckerd.org, has served as a tool for information exchange for foster and adoptive parents, child welfare service providers, and parents looking for services. It is also a tool for sharing information about training opportunities for case managers, protective investigators and other groups within the System of Care. It also serves as a repository of all weekly data packets.

ECA has been actively involved in participating in multiple community meetings. These community meetings have served as networking opportunities and have provided opportunities for services to be expanded as new contracted providers were identified. This expansion has broadened the scope of services for families.

The Manatee County Sheriff's Office (MSO) Child Protection Investigation Division (CPID) has continued to work toward improving operations within its Division. CPID incorporates the functions of the Crimes

Against Children Unit, Domestic Violence Unit, Sexual Offender Unit, and School Resource Officer Unit in conjunction with Child Abuse Investigations. With incorporating all the units in one Division there are joint efforts in investigating child abuse/neglect as well as sharing important information for more thorough assessments of participants in Child Protection Investigation reports.

The Hope Family Services Domestic Violence counselor continues to work with CPID to coordinate with investigative staff and DV Advocates to assist families involved in domestic violence cases so that immediate safety plans are developed in homes to increase the level of safety for the children as evidenced by the reduction in Family Violence Threatens Harm.

The MSO/CPID relationship of personnel has provided the agency with additional resources toward providing a comprehensive response to calls for service in the community. As a Division, MSO continues to strive for greater coordination of efforts with other agencies in the community for the benefit of the county's children and their families.

Manatee County Child Protective Services (CPS) has strong relationships with Safe Children Coalition, CLS as well as other community agencies. With experiencing a large number of lock out situations our Community Development Administrator developed a practice that has proven beneficial in driving these cases before becoming a dependency situation.

MSO networks with the Safe Children Coalition, Manatee Children's Services/Child Protection Team/Child Advocacy Center, Whole Child—Manatee, Diversion, Manatee Glens, Healthy Start, Rape Crisis, Family Safety Alliance, and other local community service organizations and Manatee County Schools through participation, presentation and referrals with the goal of reducing child abuse in the county while promoting a family centered practice.

Pinellas County Sheriff's Office CPID has tremendous collaboration with community partners in Pinellas county. Having co-located diversion, family safety, CBC, Substance Abuse provider, DV advocates, ELC, and other programs makes collaboration effective and efficient. There is constant collaboration with all major services providers, law enforcement agencies and the State Attorney's Office.

Hillsborough County Sheriff's Office (HCSO) CPID has strong relationships with the major partners in local service delivery and other stakeholders. HCSO CPID is engaged with Department of Children and Families, Eckerd Community Alternatives, Office of the Attorney General, Guardian ad Litem, Gulf Coast Jewish Family and Community Services, GracePoint, Youth and Family Alternatives, and Devereux. All of these agencies also participate in a quarterly meeting to discuss issues, system improvements, communication, etc. HCSO CPID also has relationships with the 13th Judicial Circuit, DACCO, The Spring, Hillsborough County School Board, Children's Board, Department of Juvenile Justice any other local community providers to include the Crisis Center, Champions for Children. HCSO CPID regularly attends the Community Alliance meeting held monthly with all of these providers and more.

Pasco County Sheriff's Office (PCSO), has an active relationship with the State Attorney's Office as well as judges. Pasco County has two courthouses, one on the West side of the county and one on the East side. The County's Division has identified two Judicial CPI's, one for each side of the county. These CPIs are present in the courtrooms for Shelter, Arraignment and dispositional hearings and serve as a readily accessible point of contact for our judiciary. PCSO is involved and active in the quarterly State Attorney

meetings, United Family Court Quarterly meetings, Early Childhood Court monthly stakeholder meetings, Foster Adoptive Parent Association (FAPA) monthly meetings, CMO and DJJ meetings, ASAP, Alliance, CPI DV Project Quarterly meeting, Sunrise/Salvation Army monthly DV meeting. Each of these meetings have multiple stakeholders present to discuss various topics and concerns currently occurring within the judicial system, community and within investigative and case management practices.

PCSO conducts joint investigative responses on institutional investigations. These responses involve the school board on institutional investigations and ECA Licensing on investigations involving a licensed foster parent. The Pasco Sheriff's Office provides ongoing training to the school board and local hospitals regarding child welfare changes and reporting practices. PCSO is co-located with the Sheriff's Office School Resource Officers as well as the Juvenile Diversion program. This has proven to be extremely beneficial to investigators when they have investigations involving complex youth as relationships have already been established with the family.

The GAL in this area has undergone a change in leadership. This change will allow for a rebuild in a relationship that was previously unlinked. This will be a goal in the upcoming months.

Circuit 12

Safe Children Coalition (SCC), often referred to as the **Sarasota YMCA (YMCA)**, provides services to the 12th Circuit, DeSoto, Manatee, and Sarasota Counties. The YMCA believes its role in developing community programs is to support the quality service delivery of other providers and assist them in identifying ways in which their services can better wrap around the core mission of the SCC child welfare project, as well as complement any of the several other YMCA mission-oriented programs. The YMCA believes that community-based care requires many partners working together for the common good.

In Circuit 12, communities and local stakeholders form a strong commitment and local system of collaborative linkages/relationships that focus on the community's children. This system best promotes and provides for the safety, security, and stability of children in the child protection system, and decreases time to permanency. The results-oriented system of care incorporates local communities' priorities for child safety, permanency and well-being. Local commitment and involvement assure the viability of system. This results in less service duplication and increases efficiency, with continual accountability/reporting to and evaluation from the community to ensure the system remains on course. The community-based philosophy promotes and supports innovative solution-focused approaches to achieving goals of safety, permanency, and well-being, and allows the local community to adjust these approaches based on emerging local demographics and needs. The local network of providers increases intellectual capital to solve larger system issues. This ultimately enhances the entire community's capacity and accountability for child safety, permanency and well-being.

Over the past few years, the YMCA has focused on strengthening its relationships with local governments and has been cognizant of the balance required of a lead agency that is both a funder and service provider. This has resulted in improved communication and actions that demonstrate the YMCA's desire to assure needed services are provided by the agencies with the greatest expertise. While SCC is not a major funder of prevention services, the value of these programs to the overall child welfare effort is recognized and supported.

Other Circuit Initiatives

Evidence Based (EB) Parenting and Structured Observation (SO) Training
Initiative of the Office of Court Improvement to standardize and provide quality measurements and standards for parenting programs and outcomes. Circuit 12 already had a Parenting Committee established and minimum standards for judicial cases to align program participation with permanency goals. Part of the EB Parenting requires that parents who have children ages five and under also have Structured Observations occur. This adds a layer of validity to the parent having learned new skills from the programs and reduced the risk to the child.

Structured Observation is a designed set of assessment tools developed to ensure the parental skill application of curriculum taught in community based parenting programs.

The YMCA expanded to create a faith based network of community providers (Believes Against Abused and Neglected Kids/God Raising Incredible Parents/Sanctuary Church) who have been trained as facilitators of the Nurturing Parent Curriculum and the Structured Observation tools. As non-traditional providers the faith community has expanded service options to parents in county jails, local shelters and neighborhood community centers.

Early Childhood Court (previously known as Baby Court)
The Office of Court Improvement led the statewide efforts as to Early Childhood Court. Partnerships with the Florida Center for Child Development for Child Parent Psychotherapy, intensive structured observational/therapeutic visitation, intensive case management and other wraparound support for a parent that meets screen in criteria. Families involved with Baby Court have at least five visits a week with the child ages three or under to continue to build the bonds. Contacts the parent has in counseling, parenting, etc with the toddler/baby can count toward those visitations. Assessment of application and engagement of services assists the team to determine how permanency decision making may be expedited.

The YMCA staff are regular participants in Sarasota Community Alliance meetings, Manatee CEO Roundtable, Manatee Human Services Network, Manatee Stakeholder's Consortium, DeSoto County Stakeholder's Consortium, Manatee Substance Abuse Coalition, Sarasota Behavioral Health Stakeholders, Sarasota Partnership for Mental Health, DJJ Council, Children's Committee, DeSoto Stakeholders Consortium, Sarasota and DeSoto Rotary, and the Family Safety Alliance.

SCC visited several successful CBC's to learn what they have implemented to recruit new foster home capacity in their areas. We learned that Social Media and Marketing were the biggest common denominators in all the CBC's visited. SCC then worked closely with its YMCA Marketing team to move forward with increasing our visibility in the community through these resources.

SCC has increased its social media, improved its website and expanded its exposure through local news media in the past six months. This has doubled our total number of foster parenting inquiries and increased the number of attendees to the Informational Meetings (Orientations).

SCC also learned that due to the number of children entering into the foster care system in the area, SCC would not be able to solely handle the capacity of licensing that would be needed internally. Therefore, SCC has contracted with three new licensing agency providers to meet the demand of the current systems

numbers. In addition to Florida Baptist Children's Home, SCC has contracted with Covenant Kids, West Florida and National Youth Advocate Program in August of last year.

The Sarasota YMCA partners with the Community Alliance, Sarasota County Openly Plans for Excellence (SCOPE), The Sarasota Partnership for Children's Mental Health, the Manatee Children's Services Advisory Board and the Sarasota Human Services Advisory Committee, Family Safety Alliance to assist with identifying service gaps. In addition, the YMCA continues to expand its network of service providers with a rolling Request For Applications (RFA) process, which affords interested and qualified service providers an opportunity to become eligible to deliver services on a purchase of service basis by participating in an open application process.

Circuit 20

The Children's Network of Southwest Florida (CNSWFL) is the Lead Agency in Circuit 20, Charlotte, Collier, Glades, Hendry and Lee Counties. In Circuit 20, CNSWFL has the following collaborations:

- Tribes - The Circuit has a working agreement with the Seminole tribes – Immokalee, Brighton, and Big Cypress – which includes services provision and assistance with child protective investigations and case management.
- Foster and adoptive parents - Southwest Florida (SWFL) Foster and Adoptive Parent Association - This group is actively working to improve communications within the foster and adoptive community; partner with the various organizations and providers in our area; get involved with and help improve education and training; act as a conduit for pooled resources; provide peer support and mentoring and be a collective and independent voice. They are available 24 hours a day, seven days a week to work with foster parents on any issues they might have. The association assists fellow foster parents to navigate the system and obtain the help they need.
- Substance abuse/mental health - Behavioral health consultants are collocated in each of the DCF offices in Charlotte, Lee, and Collier counties. The behavioral health consultants are available to provide immediate assessments, in-field assessments, help with the family functioning assessments (FFA), and are direct liaisons to the Community Behavioral Health agency. The Family Intensive Treatment Team (FITT) program is operational in Lee and Charlotte counties. The program provides integrated substance abuse and child welfare case management to families.
- Domestic violence - There are domestic violence advocates at each of the DCF offices and at the Lee County case management organization office in the circuit. These advocates provide an immediate DV assessment, act as liaison with the DV shelters and coordinate services for victims and their families. A representative from the local domestic violence shelter speaks routinely to trainees in the pre-service curriculum.
- Guardian ad Litem - The case management organizations work closely with guardians ad litem (GAL) to assure children in care receive the services they need. Guardians are particularly helpful in the FGCU mentoring project.
- Schools - CNSWFL works with all of the school district personnel on educational stability for children in the dependency system. Work groups have been developed and Liaisons have been established to implement the Federal Educational School Stability Act.

Southeast Region

The Southeast Region (SER) is comprised of three circuits, two Community-based Care (CBC) lead agencies, one sheriff's office that conduct child abuse investigations and five other counties where child abuse investigations are conducted by the Department of Children and Families. Each circuit is unique and diverse in the population it serves. Circuits 15 and 17 are the most populated areas serving the most children and families. Circuit 17 investigations are completed by the Broward County Sheriff's Office. The SER also works in collaboration with the Seminole and Miccosukee tribes.

Circuits 15 and 17

ChildNet, Inc. is the Lead Agency for Circuits 15 and 17. ChildNet provides comprehensive case management to families and children in Palm Beach and Broward Counties.

ChildNet firmly believes that a lead agency's constant, comprehensive, and effective work with the local network of agencies providing and funding health, education, and human services is absolutely critical to the success of any Community-Based Care (CBC) initiative. In service of this belief ChildNet, in 2002, developed a Network Management Plan (Plan). The Plan now directs ChildNet efforts in both circuits, is reviewed annually, and adjusted to reflect the unique needs and resources of each Circuit. The Plan, however, will continue to always include the following core beliefs:

- Truly successful Community-Based Care requires the fullest possible support from the fullest possible array of those who locally provide and fund medical and dental, behavioral health, developmental disabilities, juvenile justice, education, and other social services for local children and families;
- Establishing and maintaining that support requires consistent, continuing, and honest communication and partnership with all these vital CBC stakeholders; and
- Establishing and maintaining that communication and support is sufficiently important to require the focused attention of a distinct Service Coordination Department within ChildNet.

ChildNet also recognizes that each of the communities that it serves are sufficiently unique in terms of service needs and resources that the Service Coordination Department should be a local rather than regional one with its own local Department Director working directly with the local Executive Director and or Chief Operations Officer (COO). Together they oversee a team each of whose members is assigned responsibility for specified areas and activities within the local array of these health and social services.

ChildNet's Network Management Plan also clearly describes its local networks as having three (3) distinct, but equally important components: Subcontracted Services, Purchased Services, and Coordinated Services. Subcontracted Services are typically programs purchased on an annual basis through contracts with well specified outcomes and deliverables. Development, execution, and management of these subcontracts are handled by ChildNet's Contracts Department and their monitoring by ChildNet's Continuous Quality Improvement Department. However, equally important is the organized and intelligent access and management of non-contracted services, which is primarily done by the Service Coordination Department and includes both Purchased Services and Coordinated Services. Purchased services are generally behavioral health, assessment, or educational services purchased for individual clients from agencies and individual practitioners on a time-limited or unit basis. Though purchased through individual purchase orders rather than subcontracts ChildNet still requires that all these

providers, just like subcontractors, go through a formal credentialing process and all requests for such services must be approved, reviewed and, if appropriate, re- authorized by licensed ChildNet behavioral health professionals including and reporting to the Director of Service Coordination. Coordinated Services are those which ChildNet does not actually purchase but which are nonetheless provided to ChildNet clients at no cost to ChildNet by entities which are supported by other public and/or private funding. Here, rather than credentialing the provider or directly monitoring performance, ChildNet relies on its Service Coordination staff to work with the agencies and entities that support these services to confirm the appropriate licensing and credentials of these providers.

ChildNet is especially proud of its handling of Coordinated Services. These Coordinated Services include the incredibly broad spectrum of medical and dental, behavioral health (mental health and substance abuse), educational, developmental disabilities, juvenile justice, and social services funded by local entities, such as a community's Children's Services Council, Board of County Commissioners, School Board or School District, Early Learning Coalition, United Way, Managing Entity, Workforce Alliance, and statewide entities such as the Department of Juvenile Justice, the Agency for Persons with Disabilities, and the Agency for Health Care Administration. Since day one, ChildNet has recognized that the well-being and healthy development of a community's abused, abandoned and neglected children requires their fullest possible access of quality services supported by these other entities. To ensure that this happens, ChildNet relies not only on its Service Coordination Department but also on the broad and effective participation of ChildNet administrators on boards and committees that develop, administer, and monitor such services, and on the development and implementation of interagency agreements with those entities. With respect to the latter, in all circuits where ChildNet serves as the CBC lead agency, the local Executive Director supported by the local Director of Service Coordination is specifically assigned responsibility for the execution and maintenance of the statewide interagency or working agreements with the Agency for Persons with Disabilities (APD), Children's Medical Services (CMS), the Department of Juvenile Justice (DJJ), the Department of Health (DOH), the Agency for Health Care Administration (AHCA), the Department of Education (DOE), Workforce One, and any other government entity providing services to children in the child welfare system within 90 days of contract execution. Once established, the local Executive Director or Director of Service Coordination takes the lead on the implementation and management of the local agreements. In Circuits 15 and 17 this has also included ChildNet's local Executive Director, with the support of regional DCF administrators, chairing the Local Interagency Review Committees.

In addition to the following ongoing collaborations, ChildNet has entered into new ventures with additional community partners around safety management services. In Palm Beach, long-time partner Henderson Behavioral Health developed the Safety Management Action Response Team (SMART) program to work with families and ensure child safety allowing CPIs to finish their investigations. The partnership with Boys Town allows CPIs to refer families in which children have been determined to be safe; however scored high or very high in the risk assessment tool to provide family support services.

In Broward, Henderson also provides the SMART Program to families in much of the county with the exception of two neighborhoods that have been the subject of a higher number of children removed than other areas in the county. Benson-Taylor Consulting is ChildNet's partner to provide the SMART program for those two zip codes as an incubation site and along with community leaders such as the Urban League, is working to address the disproportionality of child welfare cases from those communities.

Ongoing collaborations include:

Developmental Disabilities. ChildNet has maintained a long-standing and well-developed relationship with the local Agency for Persons with Disabilities (APD) office in Broward County, and that same communication and partnership with APD in Palm Beach. ChildNet uses a centralized system for the referral of Broward's dependent children to the APD in both circuits. In both circuits a single designated ChildNet Behavioral Health Specialist is responsible for referring any local dependent children suspected of having a developmental disability to APD. Moreover, this single Service Coordination Department staff member monitors the progress of every referral and should the child be denied APD services, initiates and works with the assigned dependency case manager on the appropriate appeal process on behalf of the child. The success of this system is supported by the willingness of APD Administrators to designate a single staff member at their agency to serve as ChildNet's primary point of contact. Furthermore, ChildNet's collaboration is enhanced through quarterly APD Medicaid Waiver "wait list" staffings, where each dependent child under ChildNet's care is discussed with a multi-disciplinary team, including the child welfare case manager, APD, school representative, caregivers, therapists, and Guardian Ad Litem, in order to ensure their service needs are met and critical information is shared with all involved parties. In both circuits ChildNet has also established a process whereby designated public school system staff identifies to the assigned Behavioral Health Specialist those dependent youth with exceptional student education classifications that suggest their likely qualification for APD services. In Circuit 15 that process involves two important components to ensure its thoroughness. Upon entry into the local dependency system the school district's Court Liaisons identify for ChildNet those children whose school records indicate potential qualification for APD services. Once already in care, staff from the Exceptional Student Education (ESE) department initiate a process that identifies for ChildNet, monthly, any dependent children who have recently or newly been assigned an ESE classification that might make them similarly eligible.

Juvenile Justice. ChildNet has done multiple analyses of its teenage clients that consistently reveal that approximately half of the local teens in foster care have had at least one referral to the Department of Juvenile Justice (DJJ). This makes it imperative that the CBC lead agency's collaboration with DJJ be intense and constantly improving. ChildNet's efforts to ensure this have been, and will continue to be, aided immeasurably by the fact that ChildNet's local Executive Director in Circuit 15 and the current Regional Director for DJJ's Southern Region, which like DCF's Southeast Region includes Circuits 15 and 17, have worked effectively together as colleagues and collaborators for more than 15 years in both Broward and now Palm Beach. Together they crafted a local interagency agreement between ChildNet and DJJ in Broward several years ago which describes each agency's processes for serving shared clients and the methods for collaboration to access appropriate behavioral health services for them and their caregivers. It also describes the responsibilities of each agency in preventing the entry of delinquent youth into the dependency system via Sua Sponte order as a result of their delinquency. However, rather than simply recreate a similar document from scratch in Palm Beach ChildNet will make use of the existing Memorandum of Understanding developed by the local Crossover Committee of which ChildNet's Executive Director is now a member with representatives from DJJ, Court Administration, Legal Aid, Children's Legal Services, the State Attorney's Office, the Public Defender, and the DCF. This document does and will describe those processes and protocols that are unique to and especially effective in Circuit 15 such as the very successful Lockout Staffings facilitated by DJJ and involving the regular and active participation of a team of stakeholders from ChildNet, Legal Aid Society of the Palm Beaches, and DCF. Similarly, this document will be reviewed and updated to ensure that it accurately describes protocols for the consistent and timely notification of ChildNet when one of its clients has been taken into custody by law enforcement and referred to DJJ. ChildNet, through its participation on the Crossover Committee will also be, as it has been in Broward, an integral part of local efforts to develop and implement a schedule and curricula for cross-training of agency staff. The Crossover Committee also serves as the agency's

vehicle for developing and monitoring procedures intended to facilitate the access of ChildNet clients to available delinquency diversion programs and to increase the likelihood of their success within such programs. ChildNet is also ensuring that specialized segments of the dually delinquent youth population for whom it is responsible are being effectively and appropriately served by having the Executive Director join and work with both the local Juvenile Reentry Task Force and the Domestic Violence Subcommittee of the Juvenile Detention Alternatives Initiative. Finally, ChildNet maintains a central role in broader DJJ planning and operations as a result of the membership of the Chair of its local Advisory Board on the Circuit 15 Juvenile Justice Board.

Housing. ChildNet continues in its incredibly successful collaboration with the local housing authorities in both Broward and Palm Beach counties. Fully supported by DCF, ChildNet has made multiple applications to the federal Housing and Urban Development department (HUD) under its Family Unification Program (FUP). The most successful of these resulted in the receipt of housing subsidies valued at approximately $1.8 million dedicated exclusively to meeting the needs of either child welfare families seeking reunification of their children or teens transitioning out of the local child welfare system, an award which was the largest in the nation. ChildNet subsequently also worked with local housing authorities and behavioral health care providers on a successful application to the federal Health and Human Services administration (HHS) for a grant that now provides more than $1 million in supports to this very same population including a countywide ChildNet Housing Coordinator who assists case managers and families in the timely identification and access of all available low cost housing opportunities. In Palm Beach, ChildNet works with local non-profit organizations with particular expertise in low cost housing such as Community Partners and the Lord's Place to identify funding that would support increased housing options for child welfare clients including seeking to access FUP vouchers previously awarded to the Palm Beach County Housing Authority but not currently addressing the needs of child welfare populations. ChildNet is also continuing to develop in Palm Beach Florida Housing Finance Corporation Memorandums of Understanding for Special Needs Housing Services with major affordable housing developers. These would enable them to dedicate a specified number of units in new projects to transitional independent living youth. Similar agreements in Broward with multiple developers have produced a veritable wealth of such crucial housing units for former Broward foster care youth.

Child Protective Investigations. ChildNet's relationship with the Broward Sheriff's Office (BSO), Broward's subcontracted provider of Child Protective Investigations, well may serve as a model not only for Circuits 15 and 17 but for the entire state. The ChildNet-BSO interagency agreement describes and supports a variety of innovative and effective practices including the co-location of agency staff to assist one another with information about, access to, and follow-up on prevention and family strengthening supports and services, formalized legal sufficiency staffings and case opening documents, the use of ChildNet Shelter Court Liaisons to facilitate the transfer of information from child protective investigator to dependency case manager, and the operation of SafePlace, an around the clock one stop reception and assessment center.

Several of these practices such as the legal sufficiency staffings and case opening documents have been incorporated in Circuit 15. ChildNet opened SafePlace in Palm Beach, a child friendly reception and assessment center that houses a team of caring professionals and volunteers dedicated to addressing, timely and compassionately, the immediate trauma and the needs of children newly removed from their homes and entering the local dependency system. The 2014 opening of SafePlace was welcomed by DCF protective investigators who are freed to do more real work with families rather than looking after or transporting children and by a community eager to have children following removal immediately cared for

in a child friendly setting by sensitive and caring volunteer and professional staff from faith-based and behavioral health care organizations.

ChildNet has also readily endorsed and maintained effective systems and processes that were already put in place by DCF. These include the co-location of ChildNet's Family Resource Team staff with DCF investigators for whom it makes and follows-up on referrals for prevention, diversion, and other community based supports and services. Also valuable has been the continued convening of regular monthly Circuit 15 operations meetings at which staff from both agencies join with Children's Legal Services and dependency case management staff to describe system challenges and needs and plan their effective resolution. Those meetings and participation in statewide discussions about the Safety Methodology's implementation have been much more directed and action-oriented planning efforts led by the most senior administrators from both ChildNet and DCF and discussion around Safety Management Services continues.

Healthcare. Recognizing that children entering the dependency system have likely not previously received adequate healthcare, ChildNet has taken multiple innovative steps to ensure their timely receipt of quality medical services following their entry into the local dependency system. ChildNet established a Medical Unit specifically to ensure the timely receipt of a Well Child Check-up and the appropriate referral and receipt of services recommended by that Medicaid funded examination undertaken within three (3) days of the child's entry into the system. The Medical Unit works as a liaison with medical providers and dependency case managers to ensure healthcare needs are met appropriately and timely for children under ChildNet's supervision. Medical Unit staff work directly with the local Program Administrators of the Agency for Health Care Administration (AHCA) and their staff to resolve individual cases of ChildNet clients being unable to access appropriate and needed Medicaid funded health care services. ChildNet also was awarded a grant from the Health Foundation of South Florida to support a full-time Nurse Coordinator to follow up on the health care needs and services for children identified, at intake, with complex medical issues and needing additional medical coordination. A second nurse was added as well as a similar position in Circuit 15 due to the needs of the program. ChildNet has also developed a relationship with Pediatric Associates, an extensive medical practice with multiple locations accessible across counties, to ensure immediate well-child checks for children under its supervision.

In addition, ChildNet has been especially creative, and proactive, in responding to the major Medicaid reform initiatives mandated by the Florida legislature over the past several years. Most significant of these in the past was the creation of a targeted relationship with the South Florida Community Care Network, a partnership of three publicly funded South Florida hospital districts. ChildNet proactively entering into an interagency agreement with Sunshine Health that was approved by AHCA to provide a Medicaid Specialty Plan to Children in Child Welfare in Florida. ChildNet has embarked on working out the specific practical details of a new comprehensive and integrated system that will ensure the coordination of both medical and behavioral health services specifically designed to meet the unique and substantial needs of each and every dependent child in Broward and Palm Beach Counties.

Substance Abuse and Mental Health. Southeast Florida Behavioral Health Network (SEFBHN) is Circuit 15's Managing Entity (ME) for substance abuse and mental health serving Circuit 15 and ChildNet has been working closely with SEFBHN since it began operations on October 1, 2012. ChildNet's Executive Director in Circuit 15 is a member of the SEFBHN Board of Directors and recently was elected Secretary of that Board. He and ChildNet's Director of Service Coordination currently meet at least monthly with the ME's CEO to develop and refine the Circuit's Child Welfare Integration Plan and the interagency

agreements intended to support it. The fruits of this relationship have already been substantial. ChildNet representatives have been an integral part of the team that has developed and implemented a totally new approach to the use of Family Intervention Specialists (FIS) so that rather than continuing to unsuccessfully respond to an overwhelming demand for substance abuse assessments their efforts are now focused on working intensively with those families who either fail to follow through with such assessments which are now scheduled with an array of substance abuse providers or fail to engage in the treatment services recommended by these assessments. Though now in its early pilot stages, this new approach has displayed initial success and is an especially welcome change for ChildNet administrators who previously in Broward had attempted, unsuccessfully, to similarly recast the local FIS program.

The two agencies have also worked closely in development of the Family Recovery Program a local pilot project funded by the DCF whose overarching goal is improved integration of child welfare and substance abuse and mental health services. The program, launched in October, 2013, involves an attempt to as timely as possible engage substance abusing parents whose children are being or have just been removed in a substance abuse assessment and the treatment services it recommends. SEFBHN has provided crucial technical assistance and training to ChildNet subcontracted program staff from Community Partnership, the Lord's Place and Children's Home Society (CHS) who actually form the teams that develop and implement the service plans that facilitate more timely, safe and stable reunifications for families that participate in the pilot program.

The relationship between ChildNet and SEFBHN is extremely important given the prevalence of significant behavioral health challenges among both dependent children and their parents. It is equally imperative, however, that ChildNet work especially closely with the other entities that fund needed behavioral health services for children and families under supervision, including especially the Agency for Health Care Administration (AHCA), the state agency that administers Florida Medicaid. Accomplishing this includes supporting a team of ChildNet Behavioral Health Specialists to facilitate access to Medicaid funded behavioral health services, including Specialized Therapeutic Foster Care (STFC), Specialized Therapeutic Group Care (STGC), and the Statewide Inpatient Psychiatric Program (SIPP). One of these Master's Level staff from the Service Coordination Department, also subsequently works with the same partners to monitor the quality and effectiveness of those services, managing the referrals for and scheduling of mandated Suitability Assessments and participating in on-site visits and audits of these programs and their therapeutic services. Another designated ChildNet Behavioral Health Specialist also coordinates the provision of Comprehensive Behavioral Health Assessments, thorough reviews of child and family history and current functioning across several domains for children who have been removed from their homes. These assessments in Broward inform development of the family's case plan while differences in judicial process in Palm Beach, specifically the heavy reliance on mediation, shift their primary use to case plan modifications. ChildNet creation of a centralized referral process for these assessments and assumption of responsibility for its management has resulted in the virtual elimination of waitlists for the assessments. ChildNet Behavioral Health Specialists also review the recommendations of the Comprehensive Behavioral Health Assessment with the assigned dependency case manager to ensure their understanding and identification of needed services and appropriate service providers. Execution of these responsibilities in Circuit 15 also involves close collaboration with the Community-Based Care Partnership, AHCA's Child Welfare Pre-Paid Mental Health Plan provider in most of Florida today.

Circuit 19

Devereux Community-based Care of Okeechobee and the Treasure Coast (DCBC) is the lead Community-based Care Agency serving children and families in Circuit 19, Indian River, Martin, Okeechobee, and St. Lucie Counties.

Devereux CBC holds Memorandum of Understanding (MOU working agreement) with the following major community partners and stakeholders:

- Department of Juvenile Justice
- Child Protective Investigations
- Agency for Persons with Disabilities
- Workforce Solutions
- Healthy Families/Healthy Start
- Helping People Succeed
- Early Learning Collation
- School Boards
- Law Enforcement
- Department of Children and Families
- Southeast Florida Behavioral Health Network
- Community Based Care Integrated Health
- Children's Physicians
- Indian River Department of Health
- Florida Community Health Centers
- Children's Legal Services
- Florida Youth SHINE
- 19th Judicial Circuit Guardian ad Litem Program
- FSU School of Medicine
- Florida Atlantic University
- Barry University
- Local Housing Communities

Devereux CBC's Community Partners:

- 211
- Safe Space – Domestic Violence
- Martha's House- Domestic Violence
- House of Hope
- Tykes and Teens - YES (Youth Enrichment Services)
- The Father & Child Resource Center
- Agency for Persons with Disabilities (APD)
- Circuit 19 foster parents

- Nineteenth Judicial Circuit Drug Court
- Guardians for New Futures
- Children's Services Council's that exist in three of our four counties
- United Way
- Medicaid funded adult and children's mental health and substance abuse treatment agencies

Southern Region

The Southern Region (SR) is comprised of two circuits, 11 and 16, with one CBC lead agency and two counties, Dade and Monroe, where child abuse investigations are conducted by the Department of Children and Families. Each circuit is unique and diverse in the population it serves. Circuit 11 is the most populated area serving the most children and families.

Circuits 11 and 16

Our Kids is the CBC Lead Agency in Circuits 11 and 16. Our Kids adheres to the System of Care approach which articulates specific principles of care, including the requirement that all child-serving sectors (mental health, education, child welfare, juvenile justice, and physical health care) integrate and coordinate their service provision. Through its network of contract providers, Our Kids delivers a full range of foster care services that ensure the safety and well-being of children while creating permanency in their lives through reunification with their family or adoption.

Major community partners include Our Kids, the Department of Children and Families, Law Enforcement, State Attorney's Office, CBC Alliance, the court system, Full Case Management Agencies (FCMAs), Managing Entity (South Florida Behavioral Health Network), Florida Foster Care Review (Citizen's Review Panel), foster and adoptive parents, Miami-Dade County Public Schools, youth and service providers, and other community organizations. Some coordination is based on basic business principles and working relationships built between companies. Other relationships are formalized by contract or memorandums of understanding. Our Kids and FCMAs collaborate daily on solving problems and addressing challenges specific to our children and families. Our Kids welcomes community partners to join efforts to address the needs of the children and families in our care.

There are other community collaborations; for example:

The Children's Trust - The Children's Trust (Miami-Dade's independent special district for children's services) is a dedicated source of funding for the needs of children and families in Miami-Dade County. It is the recognized lead agency for the prevention of negative factors and the promotion of positive outcomes with funded service and advocacy programs for all children and families. The Children's Trust board has the breadth of representation (33 public, not-for-profit and private sector members), scope of expertise (with its 90 person staff) and greater resources than ever before in Miami-Dade County to focus on prevention and early intervention services to address the needs of this community's children and families.

Accordingly, while The Children's Trust programs are generally primary prevention in nature, these programs are most often targeted to offer services in the more needy neighborhoods within the community, and are sufficiently flexible to offer targeted prevention services to children and families facing vulnerabilities associated with high crime, high substance abuse, and high morbidity neighborhoods. Targeted programs in the nature of selected strategies are also funded through an array

of “service partnerships” (a new governance model for service provision) and advocacy programs. The latter are an effort to create a self-sustaining interest in prevention and early intervention services at the grassroots level, by which neighborhoods are offered the opportunity to develop their strategies for addressing negative social indicators and promoting positive community empowerment.

The Children's Trust “signature programs” continue to include quality after-school and summer camp programs, a robust health and wellness initiative, emphasis on youth development, parenting and early childhood prevention programs, the 211 Helpline, and improvement of early child care. This continuum of services intends to foster better academically prepared, more physically, emotionally and socially healthy children, youth and families.

CHAPTER II. Service Delivery Structure and Capacity

Services Continuum

The services described in this chapter of Florida's Annual Progress and Services Report reflect the primary components of Florida's child welfare system, including the case management information system. This chapter includes updates, accomplishments, and summaries for the program service array and key support activities related to the core outcomes of safety, permanency and well-being for children and families.

Florida Legislative intent provides a fundamental statement of purpose for the child welfare system that is embedded throughout the delivery of services in the state:

> (a) To provide for the care, safety, and protection of children in an environment that fosters healthy social, emotional, intellectual, and physical development; to ensure secure and safe custody; to promote the health and well-being of all children under the state's care; and to prevent the occurrence of child abuse, neglect, and abandonment.
>
> (b) To recognize that most families desire to be competent caregivers and providers for their children and that children achieve their greatest potential when families are able to support and nurture the growth and development of their children. (Subsection 39.001(1), F.S.)

In order to achieve this intent, and in alignment with the federal Principles of Practice, Florida's continuum of care includes the following general service components:

- Prevention
- Intake
- Child Protective Investigation
- In-Home Protective Services
- Out-of-Home Care
- Independent Living
- Adoption

A number of bills became law in 2016 that had an impact on children and families involved with the child welfare system. Below is a listing of the bills and a short explanation of the impact of each bill. Additional information on these major bills can be found at:
http://www.centerforchildwelfare.org/kb/flstat/2016-SessionBills.pdf

CHILD WELFARE

SB 12 – Mental Health and Substance Abuse: addresses Florida's system for delivery of behavioral health services; provides mental health services for children, parents, and others seeking custody of children involved in dependency court proceedings; requires the Department and the Agency for Health Care Administration to create an option for a single, consolidated license to provide both mental health and substance use disorder services.

HB 241 – Children and Youth Cabinet: revises the membership of the cabinet, to include the Superintendent of Schools.

HB 719 – Education Personnel: adds Department of Education (DOE) employees and agents, who investigate or prosecute educator misconduct, to the list of individuals authorized to access records relating to child abuse, abandonment, or neglect. Authorizes the DOE to use information from the Central Abuse Hotline for educator certification discipline and review.

SB 860 – Foster Families Appreciation Week: designates the second week of February of each year as "Foster Family Appreciation Week."

HB 1083 – Agency for Persons with Disabilities: makes changes to the waiver waiting list prioritization categories; allows individuals with developmental disabilities needing both waiver and extended foster care child welfare services to be prioritized in Category 2 and, when enrolled on the waiver, to be served by both the Agency for Persons with Disabilities and community-based care organizations.

HUMAN TRAFFICKING

SB 1294 – Victim and Witness Protection: increases protections for minors and victims of human trafficking including increasing the eligible age of a child victim or witness who may have his or her testimony videotaped or who may testify by closed circuit television from "under 16 years of age" to "under 18 years of age;" and increasing the age of "under 16" to "under 18" to extend the protections of court orders intended to protect a victim or witness from severe emotional or mental harm due to the presence of the defendant.

A number of other bills that became law during 2016 while not directly impacting the child welfare system, did address normalcy or well-being of children in the system and can be viewed at: http://www.centerforchildwelfare.org/kb/flstat/2016LegisChanges.pdf.

Florida Administrative Code (F.A.C.)

The Department continued to work on many of the rules started during 2014-15. To engage all stakeholders in this process the Department established four policy workgroups: Hotline, Investigations, Psychotropic Medications and Case Management. Each workgroup had cross-representation from the Regions, Sheriff Organizations, Children's Legal Services, CBC/Lead Agencies, Case Management Organizations, and Community Stakeholders.

- Chapter 65C-13, Foster Care Licensing. The Department amended several rules within Chapter 65C-13 to accomplish the following:
    - revise background screening requirements to comport with Florida Statutes;
    - revise the components of the initial licensing home study to align with the components of the unified home study in the Florida Safe Families Network (FSFN);
    - add requirements to the relicensing home study;
    - repeal duplicative language;
    - add procedural requirements regarding notification of denial of re-licensure;
    - add a quality review process;
    - require compliance with normalcy provisions of Florida statutes;

- add compliance requirements to Residential Pool Safety Act; and
- clarify requirements for bedroom sharing.

- Chapter 65C-14, Group Care Licensing effective October 20, 2016. The Department continued to work on amending Chapter 65C-14 to modify regulatory language and update forms to comport with current law, policies and procedures related to residential child caring agencies. These modifications further allow the Department to amend and repeal duplicative language in order to streamline regulatory activities within the residential child caring agency setting. Amendments include definitions; requirements regarding swimming pools; procedures regarding critical incidents; incorporation of the Partnership Plan; placement of youth; and policy and procedures for administrative actions, appeals and voluntary closures of agencies. Additionally, the Department intends to develop a rule in this Chapter for administrative actions, appeals, and voluntary closures of residential child-caring agencies.
- Chapter 65C-15, Child-Placing Agencies. The Department initiated amendments to comport with current Florida law related to child-placing agencies. The amendments in effect November 14, 2016, include incorporation of the Partnership Plan; procedures regarding critical incidents; education requirements for agency staff; requirements for volunteers, record keeping; and alignment with existing adoptions rules and laws.
- Chapter 65C-16, F.A.C., Adoptions, effective July 7, 2016. The Community-based Care Lead Agencies and their subcontractors, Children's Legal Services, adoptive parents, and other professional disciplines participated in the revisions and provided feedback. Modifications to 65C-16, F.A.C., address requirements for Sibling Separation Staffing, Match Staffing, and Adoption Applicant Review Committee members. The amendments also clarify the responsible Community-based Care Lead Agency responsible for determining eligibility and providing Maintenance Adoption Subsidy for private and public adoptions, and sets a minimum negotiation rate for Maintenance Adoption Subsidy.
- Chapter 65C-28, F.A.C., Out-of-Home Care. Modifications to Chapter 65C-25, F.A.C., address requirements for:
  - documentation in FSFN;
  - placement matching;
  - "Partnership Plan for Children in Licensed Out-of-Home Care" form supporting the Quality Parenting Initiative;
  - services to children 13 years of age and older to assist with transition to independent living;
  - home study of an absent parent (Other Parent Home Assessment);
  - child's educational needs;
  - normalcy for children in out- of- home care.
- Rule 65C-29.003, F.A.C., effective December 13, 2015. The rule amendment clarifies when a child protective investigator contacts a reporter of child maltreatment. The new language states contact is mandatory but bases the timing of the follow-up call upon the presence or absence of exigent circumstances.

- Chapter 65C-30, F.A.C., General Child Welfare Provisions, effective February 15, 2017. The modification added specific guidance about documentation in FSFN, incorporated new safety practice language definitions and associated requirements, including completion of the Family Functioning Assessment-Investigation, Family Functioning Assessment-Ongoing, Progress Update, creating and managing safety plans, conditions for return and reunification, and requirements for diligent search efforts to locate adult relatives.
- Chapter 65C-31, F.A.C., Services to Young Adults Formerly in the Custody of the Department, provides direction on the delivery of services to young adults, specifically those services provided by section 409.154(5), Florida Statutes. The rules on Aftercare and Transitional Supports Services were repealed 10/29/2015 due to statutory changes. The Department intends to repeal this entire chapter once all young adults grandfathered into the former Road-to-Independence program have completed their program eligibility.
- Chapter 65C-32, F.A.C., Parenting Course for Divorcing Parents in the State of Florida, effective April 17, 2016. The amendments:
    - require all parenting courses to be skills-based and rooted in evidence;
    - require providers to submit to the Department the resumes of all instructors;
    - clarify the approval process; and
    - clarify what must be included on the certificate of completion.
- Chapter 65C-33, F.A.C., Child Welfare Training and Certification. Effective in October and December 2015, the Department amended and repealed several rules within Chapter 65C-33, to address responsibilities to the Third Party Credentialing Entity relating to developing and administering child welfare certification programs for persons who provide child welfare services;.
- Chapter 65C-41, F.A.C., Extension of Foster Care, effective Nov. 2, 2015. The new rules address transition and case plan requirements; set forth the conditions for discharge from extended foster care; and provide an appeal procedure for young adults determined to no longer be eligible for, or denied readmission into, extended foster care.
- Chapter 65C-42, Road to Independence, effective Oct. 4, 2015. The amendments provide definitions of relevant terms; establish application processes for Postsecondary Services and Support and Aftercare Services; and provide an appeal procedure for young adults no longer be eligible for, or denied entry into, either of the programs.
- Chapter 65C-43, F.A.C., Placement and Services for Sexually Exploited Children, effective Jan. 12, 2016. The creation of Chapter 65C-43, F.A.C.,:
    - adopts standardized screening and assessment instruments to identify, determine the needs of, plan services for, and determine the appropriate placement for sexually exploited children;
    - sets forth the requirements for the use of the instruments and the reporting of data collected through their use;
    - adopts criteria for certification of safe foster homes and safe houses; and
    - specifies the content of specialized training for foster parents of safe foster homes and staff of safe houses.

Future Plans

- Revise and update 65C-9, F.A.C., Alien Children, regarding how child protective investigators and case managers work with noncitizen children families.
- Develop a rule in Chapter 65C-14, Group Care Licensing, for administrative actions, appeals, and voluntary closures of residential child-caring agencies.
- Update rule 65C-16.013, F.A.C., to reinforce the federal Title IV-E policies associated with the exploration of placement without subsidy.
- Amend rule 65C-28.018, F.A.C., to strengthen the process in maintaining school stability for children in foster care.
- Revise and update 65C-30.019, F.A.C., Missing Child Rule.

Prevention

The Department continues to administer statewide prevention and family support programs to address child abuse and neglect. Child abuse prevention and family support programs in Florida focus on the provision of support and services to promote positive parenting, healthy family functioning and family self-sufficiency. Florida funds community-based services targeting the prevention of child abuse and neglect statewide that address the needs of our multi-ethnic and multi-cultural state population.

One of Florida's strategies is to focus on prevention as a means to strengthen and support families. The Department embraces all three levels of child maltreatment prevention: primary, secondary and tertiary efforts. The Department strives for a comprehensive, cohesive, community-based prevention continuum designed to provide support to families and children. The strategy is targeted to reduce risk factors and increase protective factors to combat abuse and neglect, family disruption, substance abuse, mental illness, school failure, and criminal justice involvement. To implement such a strategy, the Department works to integrate with as many local and statewide stakeholders as possible. A common goal is to accomplish a family-centered, holistic, preventive service approach with consistent and effective messaging for Florida's families and communities.

This on-going priority is to continue to effectively engage all community partners, parents, advocates, the faith-based community, special population stakeholders, the courts, schools, health and housing programs, funders, and legislators, and sustain their role and influence over time.

A goal of the Department both on a state and local level is to have in place concrete supports for families in times of need; families with social connections; a continued focus on parental emotional resilience, nurturing and attachment as well as a knowledge of parenting and child development.

The Department and CBC lead agencies have implemented core programs and services to complement the existing network of primary, secondary and tertiary prevention programs that build upon the protective factors framework.

Update/Accomplishments

- The Department identified a need for additional Family Support Services throughout the state, including services provided to families identified as at-risk for abuse or neglect through community referrals, assessments, or calls received by the Florida Abuse Hotline.

  A Request for Proposals for Enhanced Prevention Services for Child Welfare Clients was posted; the Department selected Community-based Care lead agencies for the development of evidence-based prevention pilot programs that provide voluntary, in-home family supports when children are deemed safe but at high or very high risk for future maltreatment. These direct services will help divert families from becoming a part of the child welfare system by engaging the family in early intervention services to prevent further maltreatment.

  The pilot programs include an evaluation process that will look at how pre-selected families, currently served by the family support programs at least nine months previously, demonstrate improved outcomes.

- The Office of Child Welfare has started the process of updating and rewriting Departmental Operating Procedures to provide clear and concise guidance for child welfare professionals. Included in the updates is an operating procedure on Family Support Services.

- During the 2016 Legislative Session, the Florida Legislature allocated an additional $1.9 million to Healthy Families Florida (HFF) in order to expand and enhance services. At the direction of the Department, HHF developed a dual-model approach to enhancing the program. The purpose of the enhancement is to improve access to treatment for HHF participants experiencing substance abuse, mental health and domestic violence challenges. The HHF program model includes development of a family specialist program and a behavioral healthcare navigator program.

- Prevent Child Abuse Florida, the Department and Department of Health collaborated to provide "floor talkers" to local health departments, Community-based Care lead agencies and their subcontractors, doctor's offices and hospitals. "Floor talkers" can best be described as large posters, made of durable, non-skid material, that can be placed on floors, counter space, and walls, displaying safe sleep messaging. These posters have been extremely well-received throughout the state. "Floor talkers" have been disseminated in both English and Spanish versions throughout the state.

- A Request for Proposal, published in September 2014, resulted in the selection of a vendor to begin the evaluation process with the 2015 Pinwheels for Prevention Campaign™. The Department sought an evaluation of its current primary prevention campaign utilizing evaluation methodologies and presenting the results in a manner suitable for publication in a peer-reviewed journal. The purpose of the study is to evaluate the effects of exposure to Florida's child abuse prevention campaign materials and their impact on the attitudes of parents and caregivers. The results will have tremendous impact on child abuse prevention efforts and those who seek to allocate funds and resources towards this effort. The evaluation findings will be further discussed in the subsequent reports.

- Events from Pensacola to Key West were held in recognition of Child Abuse Prevention Month. The Director of Prevent Child Abuse Florida made stops in 15 cities and towns across Florida during the month of April 2016. Thirteen of these stops were accompanied by a 54-foot "wrapped" semi-truck. This "rolling billboard" was designed to help raise awareness of prevention and promote recognition of the everyday things community members can do to prevent child abuse and neglect. All 15 cities/towns held rallies, community events, or family fairs, providing numerous opportunities to

share the message of prevention. Specifically, this campaign focused on delivering a message of simple, everyday actions that each person can take to help prevent abuse and neglect. These events were extremely well-received and generated local media coverage on a national and statewide social media level.

Also throughout the month, events to promote awareness through “pinwheel gardens” occurred at almost all state agencies. Cities and local municipalities also participated with the adoption of the official state proclamation of April as “Child Abuse Prevention Month” or, in some cases, issuance of their own local proclamations.

Children’s Week at the Florida State Capitol was held in January, drawing thousands of children, families and advocates to the state capital. Children’s Week at the Capitol occurs each year in concert with the Florida Legislative Session.

The week begins with the “hanging of the hands” in the Capitol rotunda. Tens of thousands of creations of "hand art" displayed throughout the Capitol rotunda present an amazing display of children's art. “Hand art" decorated by children and their teachers, and collected at child care centers and schools across the state serve as a reminder to legislators and advocates that we must take care of Florida’s children.

Children’s Day at the Capitol features breakfast for the children and families who attend the interactive day. A storybook village, operated by partners and volunteers, offers children an interactive reading experience and booths for children to explore depicting scenes from popular books.

A Teen Town Hall meeting provides a forum and voice for students from across the state to work with Florida’s Children and Youth Cabinet to address issues important to children’s services. A press conference includes legislators, leaders, and child advocates from across the state celebrating Children’s Week and highlighting and addressing important issues related to children.

Future Plans

Please refer to Chapter VIII, CAPTA.

Intake

The single entry point to child welfare services in Florida is the Florida Abuse Hotline. All child abuse and neglect allegations received through the centralized Florida Abuse Hotline located in Tallahassee, occurs twenty-four hours a day, seven days a week. There are several ways to make a report: the toll-free telephone number (1-800-96-ABUSE), including through telecommunication devices for the deaf and hard-of-hearing; by fax; and electronically via the Department’s internet website.

Florida Abuse Hotline counselors assign child protective investigation response times to ensure quick identification of where the child will be during the next 24 hours, and whether there are any potential dangers to the child protective investigator. In addition, Hotline staff increase the quality of the initial contact with the child and family by giving child protective investigators important criminal history and law enforcement information prior to commencing an investigation. This provides the investigator with more complete information on-hand to make safety assessments and improve front-end decision-making.

Upon receiving and accepting a report for an allegation of abuse, neglect, and/or abandonment, Hotline counselors generate a report in Florida Safe Families Network (Florida’s Statewide Automated Child

Welfare Information System - SACWIS), which is then forwarded to crime intelligence staff to complete criminal history checks. The complete abuse/neglect report is then forwarded to the appropriate investigative office in the county where the investigation will occur.

There are times when the Hotline is contacted for children in need of services or supervision from the Department and there are no allegations of abuse, neglect or abandonment. The Department considers circumstances such as these special conditions reports with established guidelines and specified acceptance criteria. If the threshold for report acceptance is met, reports are generated using the same process as abuse, neglect and abandonment reports and submitted for social service responses aimed at linking families with community services, if requested.

In addition to assessing allegations of abuse, neglect and abandonment of a child by a parent or caregiver, juvenile sex abuse allegations are also assessed when there is an allegation that a child perpetrated a sexual (physical or non-physical) act on another child. These reports are categorized as child-on-child sexual abuse reports and evaluated against established report acceptance criteria. Regardless of report acceptance, the Hotline refers all instances of child-on-child sexual abuse to the local sheriff's agency to report the allegations.

Hotline crime intelligence staff complete criminal history checks for investigations to include subjects of the investigation for both child and adult abuse reports, other adult household members, and children in the household 12 years or older. Staff also complete criminal history checks for emergency and planned placements of children in Florida's child welfare system.

The type of checks performed and data sources accessed for investigations or placements are based on the program requesting the information as well as the purpose of the request (investigations or placements). The Florida Abuse Hotline crime intelligence staff members have access to the following criminal justice, juvenile delinquency, and court data sources and information:

- Florida Crime Information Center (FCIC) – Florida criminal history records and dispositions;
- National Crime Information Center (NCIC) – National criminal history records and dispositions;
- Hotfiles (FCIC/NCIC) – Person and status files such as: wanted person, missing person, sexual predator/offender, protection orders;
- Department of Juvenile Justice (JJIS) – Juvenile arrest history;
- Comprehensive Court Information System (CCIS) – Florida court case information;
- Department of Highway Safety and Motor Vehicles (DAVID) – Driver and Vehicle Information Database (current driver's history, license status, photos, signature);
- Department of Corrections (DOC) – current custody status, supervision, incarceration information;
- Justice Exchange Connection– Jail databases for current incarcerations, associated charges, and booking images.

When a CBC is considering a placement, the agency must contact the Florida Abuse Hotline, Background Screening Unit, and request criminal history record information on potential caregivers for a child requiring removal from his or her current residence.

Fingerprint submissions must be obtained within 10 days for all persons in the placement or potential placement home over the age of 18 years following the Hotline's query of the NCIC database for the purpose of a placement initially requested by an investigator or case manager.

The addition of statutory language on investigation and placement criminal background screening more clearly defined in Chapter 39, Florida's dependency statute, the federal requirements for criminal background screening for adoptive parents, relative and non-relative placements.

Situations reported to the Florida Abuse Hotline that do not rise to the level of a protective investigation may be addressed as a "prevention referral." This practice is designed to give the Department an opportunity to help communities identify and provide services for families in order to avoid formal entrance into the child welfare system. The Department tracks and monitors such prevention referrals, which are called "Parent in Need of Assistance."

Update/Accomplishments

- The Hotline received a case review conducted by Action for Child Protection of screened-out reports in February 2016. "The focus of the review was to assess the quality of information collection and decision making as it reflects the implementation of the Florida Safety Decision Making Methodology." The summary report of findings acknowledged high rates of agreement along with opportunities for improvement.
- The Hotline implemented a series of technology initiatives designed to maximize available workforce.
    - Updates to the telephone system enabled calls to be routed to certain skilled counselors. Certain units are designated to handle exclusively reporters calling in concerns about an adult, or child, or those seeking information and referral assistance. The ability to match skill set by type of caller enabled the development of performance metrics specific to certain types of reports as well as certain reporters.
    - Technology enhancements to the workforce management software created and verified compliance and qualitative assessment standards for individual counselor performance.
- The Office of Child Welfare conducted a review of screened-out reports of substance-exposed infants in July 2016. As a result of the review, new policy was implemented regarding assessment and screening criteria for reports of parental substance use involving children age 0-12 months.
- In February 2016, the operating procedure that guides screening decisions at the Hotline and findings of maltreatment related to investigations was updated. The Child Maltreatment Index is a critical part of supporting consistent decision-making within our child welfare system.

Future Plans

- The Hotline will participate in a benchmarking study of the "front end" of Florida's child welfare system, conducted by the DCF Office of Planning and Performance and Casey Family Programs, which will include reporting, intake screening criteria, and child protective investigations. The study's findings will be available for the 2017 Legislative Session.
    - The purpose of the front-end benchmarking study is to "normalize Florida's current child welfare system" and propose legislative changes, including efficiencies to streamline the system without compromising safety.

- The study findings will "consider potential imbalances in Florida's child welfare system that might impact the efficient and effective management of available resources to meet all stakeholder needs with consistency and quality of performance."

The report will present evidence on key drivers of child welfare outcomes from Florida and the two benchmarking partner states (Alabama and Texas). Additionally, it will project the impact of the proposed changes to Florida's rates of reporting, intake acceptance, and substantiation.

Protective Investigation

Child protective investigations are designed to respond to reports of abuse and neglect for the purpose of assessing for Present Danger (active/immediate threats to child safety) during the initial on-site visit to the home and for the overall determination of child safety (based upon the identification of Impending Danger or on-going pervasive danger in the household). The identification of both Present and Impending Danger requires the immediate development and implementation of a safety plan with the child's caregivers to control for the danger threat(s) in the home. Investigators initially determine the feasibility of an in-home safety plan, but if all safety plan criteria cannot be met, the child is placed in an out-of-home setting with relatives or a non-relative, or in licensed care. Child protective investigations and related legal actions are subject to prescriptive statutory requirements in Chapter 39, Florida Statutes.

The Department is responsible for conducting child protective investigations in 61 of 67 Florida counties. Sheriff's offices in the remaining six counties (Broward, Hillsborough, Pasco, Pinellas, Manatee and Seminole counties) conduct child protective investigations through grants. Child protective investigations involve three types of settings. In-Home investigations with a parent or legal guardian as the alleged perpetrator comprise the largest share of investigations. A second, much smaller subset of In-Home investigations involve alleged maltreatment by a caregiver outside the child's home (e.g., weekend visit with grandparent, adult babysitter caring for the alleged victim in the child's or sitter's home, etc.) or reports involving human trafficking when the alleged perpetrator is not the child's parent or legal guardian. The third significant type of child investigation is defined as Institutional reports which involve alleged maltreatment in an institutional setting (e.g., school, child care, foster home, etc.) or by a person legally responsible for a child's welfare per Florida Statute.

Florida's child welfare practice model provides a set of common core constructs for determining when children are unsafe, the risk of subsequent harm and how to engage caregivers in achieving change. The Abuse Hotline first gathers information related to the presence of Present or Impending Danger and the nature and extent of the alleged maltreatment. The child protective investigator gathers additional information related to six specific information domains in order to determine: (1) the presence of danger threats; (2) if a child is vulnerable to an identified threat; and (3) whether there is a non-maltreating parent or legal guardian in the household who has sufficient protective capacities to manage the identified danger threat in the home. The totality of this information and interaction of these components are the critical elements in determining whether a child is safe or unsafe. The investigator also completes a risk assessment for each In-Home investigation to determine the likelihood of subsequent harm. All safe but high or very high risk households are encouraged to work with Family Support programs to reduce the risk of future maltreatment.

The same core constructs guide actions to protect children (safety management) and support the enhancement of caregiver protective capacities (case management). The case planning process is based

on an understanding of the stages of change and the logical progression that is most likely to result in successful remediation of the family conditions and behaviors that must change.

Update/Accomplishments

- During the report period, the implementation of Florida's child welfare practice model has remained the primary focus for the Department. Using implementation drivers, Florida has continued its journey through initial implementation, focusing on skill-building and staff development, using data and continuous quality improvement to further model fidelity, operationalizing the practice through policy and guidance, and supporting the practice through leadership and FSFN (SACWIS) functionality.
- Florida has invested significant resources in organizing statewide workgroups and work sessions with national experts to plan and focus implementation efforts. The Child Welfare Practice Task Force, formerly known as the Statewide Safety Methodology Steering Committee (SMSC), active since 2013, advises and organizes various subcommittees to support implementation. The Task Force has the responsibility to lead, guide, direct, and advise the statewide implementation of major initiatives and guides the administration of the Children's Justice Act Grant (CJA Grant). The CJA Grant mandates that a Task Force be created to advise the Department of Children and Families regarding the spending of the grant funds to improve child protection initiatives in Florida. The Task Force also provides a forum to make sure that the child welfare practice model continues to be implemented with high fidelity. Additionally, the Task Force oversees the implementation of Florida's Program Improvement Plan (PIP) resulting from the findings from the 2016 Child and Family Services Review (CFSR). The Task Force members act as the vocal and visible ambassadors throughout the state and as representatives of their specific fields of expertise. The team meets quarterly to carry out its charge and receive updates from its various subcommittees.

  The subcommittees are:

  - Policy and Practice Subcommittee
  - CQI Subcommittee
  - Supervisors Subcommittee

  The Policy and Practice subcommittee ensures the practice operationalized in the field is aligned with Florida's core tenets and model fidelity. This subcommittee worked for months to develop operating procedures that would support the field in operationalizing the practice model concepts. The operating procedures are posted at: http://centerforchildwelfare.fmhi.usf.edu/HorizontalTab/DeptOperatingProcedures.shtml

  - Further development and enhancement of operating procedures continued during the reporting period. The Policy and Practice subcommittee progressed to three parallel tracks working on operating procedures simultaneously, focused on a hotline track, child protective investigations track, and case management track. The Policy and Practice subcommittees have worked throughout the report period to convert the practice guidelines to operating procedures. This process is continuing.
- Action for Child Protection completed two rounds of model fidelity reviews/case reviews using a statewide sample to help Florida assess and establish baseline indicators of how the state is progressing collectively and where the state needs to concentrate its resources to achieve full operation.

- As part of the *Structured Decision Making®* (*SDM*) initial risk assessment's implementation, NCCD Children's Research Center (CRC) reviewed completed risk assessment reviews and related narrative documentation to identify staff strengths and issues with the risk assessment completion.
- The Department continued its proficiency process of the Critical Child Safety Practice Expert (CCSPE) positions. The primary role of the CCSPE is to review open child protective investigations and provide guidance to child protective investigators. The CCSPEs coach and mentor staff to ensure that sufficient information is being gathered and assessed around child safety and family functioning. This guidance helps ensure child protective investigators (CPIs) are making the right decisions during the course of the protective investigation. The proficiency process is discussed in detail in Chapter IV.
- The Department implemented a credentialing process for CPI quality assurance (QA) staff. Although this process will not be as rigorous as the CCSPE practice expert training, QA staff are required to become proficient in the practice model. This approach was developed to help improve the fidelity of CPI casework activities.
- The Office of Child Welfare completed visits to each of the six regions to assess implementation and operationalization of the practice model. These visits included a self-assessment from the regions on implementation, a process-mapping activity involving front-line staff that showed how the practice was operationalized regionally, and meetings with each Community-based Care lead agency to begin an assessment of their service array. As a result of the findings of these visits, a statewide implementation plan was developed to focus on activities needed to further the practice.
- Following the regional visits, efforts to complete a more in-depth assessment of each Community-based Care lead agency's service array began. The Department completed the in-depth assessments of Family Support Services (prevention services) for safe children and Safety Management Services during the report period and set baselines. The assessment of Treatment and Child Well-being Services will begin in July 2017.
- The Office of Child Welfare partnered with the regions to facilitate four statewide supervisory trainings aimed at enhancing supervisory consultations, fidelity to the practice model, and leadership and team-working.

Future Plans

- The policy and practice subcommittees will continue with the effort to convert practice guidelines into operating procedures. Additionally, efforts will begin in the complete review and update of all operating procedures with a goal of completion by December 2017.
- Action for Child Protection will continue regular fidelity reviews to help assess progress toward fidelity to the practice model.
- Additionally, the Office of Child Welfare (OCW) partners with the Florida Institute for Child Welfare and Action for Child Protection and will begin an inter-rater reliability study of the rating of the caregiver protective capacities.
- As part of the *Structured Decision Making® (SDM*) initial risk assessment's implementation, NCCD Children's Research Center (CRC) will complete case reviews for completed risk assessments and related narrative documentation to identify staff strengths and issues with the risk assessment completion.

- Department of Children and Families Child Protection Investigations Supervisors and Program Administrators are charged with critical performance expectations to serve the most vulnerable clients: children. Supervisor proficiency is critical in ensuring adherence of fidelity to the Florida Child Welfare Practice Model and in addressing child safety threats with the sense of urgency needed. A proficiency process is being developed to assess the ongoing development of skill in the area of coaching, supervising, and consulting for Child Protection Investigations Supervisors and Program Administrators as it pertains to Florida's Child Welfare Practice Model. This process will establish a formalized proficiency process for the Department of Children and Families and apply it to staff who are responsible for conducting case consultations and for direct supervision of investigators.

    - The proficiency process will assess three core skill areas:
        - Understanding of the Practice Model constructs/elements.
        - Ability to provide consultative feedback through discussions and written analysis.
        - Ability to provide a learning opportunity for staff development.

In-Home Protective Services (Protective Supervision)

The Office of Child Welfare published a new operating procedure, CFOP 170-9, Family Assessment and Case Planning, on May 11, 2016. This resulted from a lengthy development process involving the statewide Case Management Policy workgroup. This operating procedure provides comprehensive statewide standards for family engagement during every stage of a child welfare case transferred to the CBC lead agency. The standards provide for the on-going assessment of caregiver protective capacities and child well-being indicators, whether the case involves in-home protective services or out-of-home care. The standards for family engagement include child and family assessment, identifying family change strategies and barriers to change, co-constructing case plans and collaborating in the on-going assessment of progress.

CFOP 170-7, Chapter 4, published in June 2016, establishes clear and specific guidance for determining whether it is safe to create an in-home safety plan with protective supervision. A "Safety Analysis" is prepared at the conclusion of an FFA-Investigation, FFA-Ongoing or Progress Update that summarizes the conditions in the home. There are five criteria that family conditions must meet in order for a child welfare professional to establish an in-home safety plan. If any of the criteria for an in-home safety plan are not met, the child must be placed out-of-the home. Conditions for Return are established to clarify what family condition must change, what it must look like, in order for an in-home plan to be created and the child reunified. After reunification, the child will have an in-home safety plan and the family will continue to receive the services necessary to help them achieve their case plan outcomes.

CFOP 170-7, Chapter 8, also establishes safety management service categories and types (Behavior Management, Crises Management, Social Connections, Resource Support, and Separation Safety). These categories reflect the full array of safety management services that should be available to support the creation of safety plans. A comprehensive array of safety management services must be available to support in-home safety management. As part of each region's implementation self-assessment and planning, each region identified the need to strengthen their safety management service array.

A significant portion of the Department's safety management service array for families under in-home protective supervision is linked to the Promoting Safe and Stable Families program, as described in the

Promoting Safe and Stable Families (starting on page 83). Availability of each type of service depends on the local CBC service structure and system of care to address community needs and population differences.

Out-of-Home Care

Placement

The processes and choices involved in placement are crucial to ensure the Department is providing the safest and most appropriate care for children who are unable to live in their own homes until a permanency goal is attained. The most appropriate available out-of-home placement is chosen after assessing the child's age, sex, sibling status, special physical, educational, emotional and developmental needs, alleged type of abuse, neglect or abandonment, community ties, and school placement.

Consideration for placement is from least to most restrictive based on the child's needs. Initial placement decisions for the least restrictive placements, such as relative and non-relative placements, are made by the front line staff and their supervisors. After initial emergency placement, placement services are coordinated by the Community-based Care (CBC) lead agencies. This provides an increased local community ownership of ensuring the right out-of-home care placement for children. Communities coming together on behalf of their most vulnerable children demonstrates what community-based care was designed to do: transition child welfare services to local providers under the direction of lead agencies and community alliances of stakeholders working within their community to ensure safety, well-being, and permanency for the children in their care.

In making a placement with a relative or non-relative, front line staff consider whether the caregiver would be a suitable adoptive parent if reunification is not successful and the caregiver would wish to adopt the child.

With the implementation of the new practice model (see discussion of this approach to practice in Chapter IV), case managers now have responsibility for assessing when a safety plan in an in-home case is no longer sufficient to maintain the child's safety. At this juncture, the case manager and supervisors determine the next least restrictive placement for the child, and work with the birth family to establish conditions for return and the behavior changes needed. Out-of-home caregivers receive this information as part of a coordinated effort by the birth family, the CBC case manager, and the out-of-home caregiver to work toward meeting the conditions for returning the child home.

Except in emergency situations or when ordered by the court, licensed out-of-home caregivers must give at least two weeks' notice prior to moving a child from one out-of-home placement to another. During these two weeks a transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home and, if possible, for continued contact with the caregiver after the child leaves.

Placement options

There are permanency options in Florida law to preserve family connections by giving children an opportunity to be raised within the context of the family's culture, values and history, thereby enhancing

children's sense of purpose and belonging. For a number of children, guardianship or placement with relatives or non-relatives may be an appropriate permanency option, in accordance with federal and state provisions. An ongoing commitment is to support this option for children and de-emphasize the use of licensed out of home placement.

Licensed out-of-home placements (foster homes and residential group facilities) comprise less than half of the placement settings for children in out-of-home care. The number of children in shift care settings continues to drop, and there is a new focus on establishing quality guidelines for group care for dependent children. There are continuing challenges in Florida, as well as nationally. These include the recruitment and retention of quality foster homes; ensuring that the balance among safety, permanency, and well-being is maintained; providing placements that match children's characteristics and needs, particularly for special populations such as teens and children with disabilities; and declining resources.

Out-of-home care offers case management services to children in out-of-home care when the child cannot remain safely at home and needs temporary out of home care while services are provided to reunite the family or achieve some other permanency option. As directed by the Florida Legislature, the state has outsourced all foster care out-of-home care and related services in an effort to better encourage the engagement of communities and local stakeholders to become partners in promoting issues associated with child safety, permanency and well-being. Florida's contracted non-for-profit Community-based Care lead agencies (CBCs) provide and oversee out-of-home service activities, as well as related services such as in-home care, placement, and permanency, for their particular area of the state. CBCs also work closely with subcontracted service providers and provide training and technical assistance related to funding criteria and rules in support of collaborative and successful use of resources.

Kinship Care

Along with licensed foster homes and group homes, relative and non-relative placements are an additional option offered under out-of-home services and placements. Relatives and non-relatives who request placement must be capable, as determined by an approved home study, of providing a physically safe environment and a stable supportive home for the children under their care. They must also assure that the children's well-being needs are met, including, but not limited to, the provision of immunizations, education, and mental health services.

Relatives or non-relatives who become out-of-home placements are not required to meet foster care licensing requirements but must have an approved home study prior to obtaining placement of a child. The Department provides financial assistance to relatives through the Relative Caregiver Program and the Non Relative Caregiver Program.

The Relative Caregiver Program is an option service offered to relatives. The Relative Caregiver Program provides financial assistance to:

- Relatives who are within the fifth degree by blood or marriage to full-time for that dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative.
- Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child, and a dependent half-brother or

half-sister of that dependent child, in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative.

The Non Relative Caregiver Program is an option service offered to non-relatives. The Non-Relative Caregiver Program provides financial assistance to:

- Non-relatives who are willing to assume custody and care of a dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the nonrelative caregiver. The court must find that a proposed placement is in the best interest of the child.

Update/Accomplishments

- The Department continued to support the Non-Relative Caregiver Payment Program using the existing appropriation and requested additional general revenue funding from the Legislature to continue the program.
- The Department hired a restorative practices specialist. This position promotes integration between the child welfare (DCF), education (DOE), and juvenile justice (DJJ) systems with regard to the use of restorative practices for children served by the Department; serves as the Office of Child Welfare's representative on the implementation training and ongoing coordination of restorative practices throughout the State.

Future Plans

- The Department will complete the review of the current gap between the number of children who are currently receiving benefits from the relative caregiver program and the number of children who are potentially eligible in an effort to identify barriers to the relative caregivers participating in the program.
- The restorative practices specialist position will also work closely with CBC staff to provide restorative practices training relating to restorative justice, family group conferencing, dialogue circles, and Nonviolent Communication is ongoing.
- The Department will begin to develop a pilot to train staff at a local group home on topics relating to Nonviolent Communication and Restorative Practices. This pilot will serve as the first site for the state for this level of training. Pre- and post-training surveys will be administered to collect data about relative levels of connection and support within the group home.

Another Planned Permanent Living Arrangement (APPLA)

As detailed in section 39.6241, Florida Statutes, if all other permanency options (reunifications, adoption, permanent guardianship, or placement with a fit and willing relative) are not in the best interest of the child then Another Planned Permanent Living Arrangement is used.

A compelling reason must also been shown as to why placement in another planned permanent living arrangement is the most appropriate permanency goal. Compelling reasons for such placement may include, but are not limited to:

1. The case of a parent and child who have a significant bond but the parent is unable to care for the child because of an emotional or physical disability, and the child's foster parents have committed to raising him or her to the age of majority and to facilitate visitation with the disabled parent;

2. The case of a child for whom an Indian tribe has identified another planned permanent living arrangement for the child; or

3. The case of a foster child who is 16 years of age or older who chooses to remain in foster care, and the child's foster parents are willing to care for the child until the child reaches 18 years of age.

Another Planned Permanent Living Arrangement (APPLA) is typically utilized as a concurrent permanency goal. Therefore, cases with APPLA as a permanency goal receive the services attached to the primary permanency goal. Examples of some of these services include: independent living services; medical, dental, educational, or psychological referrals; and various services to meet other needs, as recommended by the caregiver.

Case management supervision and treatment services that children may need are continued until another permanency option is reached or the child reaches the age of majority, 18.

Update/Accomplishments

- The Department has seen a reduction in the number of children with an APPLA goal from 487 children in foster care in September 2014 to 385 in September of 2016.
- The Department published CFOP 170-9, Family Assessment and Case Planning, effective May 11, 2016, to provide procedures on all permanency options, including APPLA.
- The Department continued its partnership with Casey Family Programs in implementing the Permanency Roundtable (PRT) processes. To date, 13 CBCs have implemented PRT processes.

Future Plans

- The Department will continue its partnership with Casey Family Programs in implementing the Permanency Roundtable (PRT) process. For more detail around this plan, refer to the Foster/Adoptive Diligent Recruitment Plan in Appendix B.
- The Department will continue to implement the provisions in the Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183) that limits APPLA as a permanency goal for youth age 16 and older.

Services to Those Most at Risk

Every age and stage of child development has different challenges and vulnerabilities, and child welfare is concerned about all of them. Two particular focus areas, very young children and children who are victims of domestic human trafficking, are highlighted.

Children ages 0-5

The proportion of the youngest children in need of permanency, and their length of stay in out of home care, is fairly constant. The Department, in collaboration with its Community-based Care partners, is

continuing efforts to reduce the number of children ages five and under in shift care placements, and increase developmentally appropriate treatment options. These efforts improve well-being and normalcy for children, while also enhancing permanency.

- On-going efforts to place children ages five and under in a more family-like setting have been underway since February 2009.
- Children ages 0 to 17 entering out-of-home care, who are Medicaid eligible, receive Comprehensive Behavioral Mental Health Assessments (CBHA) by a licensed mental health professional almost immediately after removal. This assessment encompasses developmental needs of the child, which is particularly important for the very youngest children.
- A part of the child welfare practice model in Florida has been expanded to include the assessment of child functioning and vulnerability. Case managers are responsible for ensuring that any impending danger safety plan is working dependably to keep the child safe. The case manager is responsible for continuously assessing and confirming that the ongoing safety plan is controlling for danger threats and is the least intrusive and least restrictive intervention available.
- Florida has established the Child Welfare Specialty Plan (CWSP). The CWSP is a Managed Medical Assistance (MMA) program specialty managed care plan for Medicaid eligible dependent children receiving services from Florida's child welfare system. Sunshine Health, a Florida-based managed care plan, was awarded a five-year contract by the Agency for Health Care Administration (ACHA) in 2014 to administer the CWSP. ACHA, in collaboration with the Department, contracted with the Louis de la Parte Florida Mental Health Institute, University of South Florida to conduct a comprehensive study of "Access, Integration of Care and Service Utilization for Child Welfare Involved Children in Florida's Managed Medical Assistance Program." This study is assessing access to care, integration of services and services utilization for child welfare involved children enrolled in the CWSP and other MMA plans.
- Developmental services such as speech and language therapy, occupational therapy, and physical therapy are included in the Medicaid State Plan for children. The Department works closely with the Early Steps Program. The Early Steps Program administered by Children's Medical Services (CMS) in accord with IDEA, Part C. offers services specifically designed for children under the age of three with developmental delays. Children three and older with a developmental disability may be eligible for specialized developmental services through the Agency for Persons with Disabilities (APD). As with mental health services, children in the child welfare system have a high level of need for health care services and coordination of care.

<u>Update/Accomplishments</u>

Statewide

- On-going efforts continue to recruit homes and place children ages five and under in a more family-like setting.
- Substance-exposed infants present a particular challenge. Births of substance-exposed infants are called into the Hotline for investigation, and subsequent intervention in confirmed cases is crucial.

Collaboration with the Substance Abuse and Mental Health community is a key factor in addressing this issue.

"Born Drug Free Florida" is an initiative by the Florida Department of Children and Families, Florida Office of the Attorney General and the Florida Department of Health to raise awareness about babies being born exposed to prescription drugs. The campaign educates expectant mothers about the importance of discussing prescription drug abuse with their doctors and to offer assistance to the women. It is dedicated to assisting pregnant women who are taking prescription medication with information and referral services to Department approved behavioral healthcare facilities. Women can reach the Born Drug Free helpline at 1-800-945-1355 or access information at http://www.borndrugfreefl.com.

- The Department continued to support the Early Childhood Court initiative, a Florida Court Improvement lead project. Early Childhood Court addresses child welfare cases involving children under the age of three. It is a problem-solving court – where legal, societal, and individual problems intersect. Problem-solving courts seek to address not only the legal issues but also the underlying non-legal issues that will benefit the parties and society as well. This specialized court docket provides greater judicial oversight through more frequent judicial reviews and a multidisciplinary team approach. The team works in a non-adversarial manner to link the parties to treatment and services.

  The Department is a full partner in this initiative on a statewide level and local community level. Collaborative partners include the Community-based Care agencies, Florida State University, Children's Legal Services, mental health providers, infant mental health specialists, foster parents, and other community partners.

Local Accomplishments, include but are not limited to:

- The Early Childhood Court Project is a specialized dependency court program in Escambia and Okaloosa Counties. The Early Childhood Court Project focus is on addressing the needs of families who have come into the purview of the court system because they have abused or neglected their children who are aged birth to three years old. The program utilizes existing community resources to provide a coordinated and integrated approach to address the underlying issues of abuse and neglect while at the same time enhancing the parent-child relationship and improving permanency outcomes, safety and well-being of the children enrolled in the program. The program is unique in that it intervenes at the family level rather than the individual family member level. Every member of the family is provided services that they need to enhance family stability and child well-being.

  The Escambia County Early Childhood Court Team consists of: Dependency Judges, CLS, Parent Attorneys, GAL, Court Administration, Dependency Court Resource Facilitator, Child Welfare Professionals (Child Protective Investigators and Family Services Counselors), Community Mental Health, Substance Abuse and Domestic Violence treatment, agency service providers, Community Prevention and Early Intervention Providers, Early Learning Coalition (ELC) and Healthy Start.

- In Circuits 2 and 14, FIT (Family Intensive Treatment) Teams provide intensive treatment interventions targeted to substance abusing parents of unsafe children, ten years old and younger that are involved in the child welfare system. These teams are family-centered and work to integrate treatment for substance use disorders, parenting interventions and therapeutic treatment for all family members into one comprehensive treatment approach. These teams include a Behavioral

Health Clinician, a Case Manager and a Peer Specialist, and in some cases a Program Manager. Currently, BBCBC has FIT Teams in all circuits in the Northwest Region and these teams are currently serving 101 families.

- BBCBC has been an active member of the Early Childhood Mental Health System of Care grant for the past five years. In September of 2016, the grant entered a second phase, expanding the opportunities to better serve the community with service dollars. BBCBC is in negotiations with DCF to administer the service dollars within the counties covered by the grant. While both Bay/Washington and Leon/Gadsden have different initiatives, the four counties are working together to determine the best use of service dollars. Currently, the two sites are hoping to expand High Fidelity Wrap Around services as well as the developmental screening of young children (the ASQ-SE).
- The Northeast Region has participated in cross training with the Child Protection Team (CPT) during their annual conference. For the development of CPI Subject Matter Experts in Medical Neglect, the Region partnered with CPT and other health providers to provide Specialized Medical Neglect training, such as for youth with Asthma, Diabetes, Failure to Thrive, Dental Neglect, Obesity and Medically Complex conditions. During these partnership, the team developed medical neglect checklists, placed on DCF letterhead and adopted by the Office of Child Welfare (and the Department of Health) as statewide forms for CPI use. These checklists were distributed and trained on during the 2016 Child Welfare Dependency Summit. The Region further developed a Medical Neglect Protocol to outline applicable standardized procedures for response to reports received with allegations of Medical Neglect (MN) and to enhance the quality of investigations when addressing medically complex children.
- Community Partnership for Children has continued its Early Childhood Court (ECC) Team in partnership with its Infant Mental Health Chapter. Families with children 0-3, who having a history of domestic violence or substance abuse, with one parent under 28 years old are referred to the ECC Team program. The program goal is to expedite permanency, through intensive visitation, family team meetings, expedited referrals, and Child Parent Psychotherapy. Quarterly ECC Stakeholder meetings take place with the community to discuss ways community agencies can support the program. CPC also implemented the ECC core team meetings for those professionals involved in ECC to discuss our internal process and any barriers/challenges.
- Family Support Services of North Florida Inc. (FSSNF) continued to utilize the statewide Rapid Safety Feedback Reviews for children ages 0-3. These focused reviews use a standardized tool that directs the attention of the reviewer to five casework practices that impact child safety. At the conclusion of each review, the Quality Management (QM) Specialist provides consultation to the case manager and case manager supervisor about strengths and areas needing improvement in the case work practice. Deficiencies that could be corrected are monitored by the QM Specialist until appropriately modified. This review process was well received by case managers and has improved casework practice around assessing safety, developing safety plans, and monitoring parents.
- FSSNF has a designated a Quality Management (QM) Specialist position to focus on children ages zero to three. This past year, the lead QM Specialist conducted three ongoing reviews for children 0-5 years old and develops and provides training related to this population to case managers as needed. The ongoing reviews are: Out-of-home targeted well-being and permanency reviews focused on children who have been out of the home for more than 12 months with a goal of Reunification; Review of home studies and background screening when children ages zero to five are placed with relatives or non-relatives by the case manager, and review of progress update, background screening,

and compliance with safety plan when children 0-5 are reunified. The QM Specialist notifies service providers of noted deficiencies upon completion of each review and monitors the case until the deficiencies are corrected. Data indicates overall improvement in casework practice by all service providers for this most vulnerable population.

- Family Preservation Oversight Coordinators also have a dedicated process in place to review cases that include children ages zero to three. Cases where continued barriers are identified are then referred to the Integrated Practice Team (IPT).
- Family Support Services of North Florida coordinates with other services through a Child Welfare Early Education Program (CWEEP) grant that created an infrastructure between child welfare agencies and the leading agencies for childcare and early education services. The program goal is to increase the likelihood that children under five years old participate in high quality early education programs that improve school readiness and lifelong outcomes.
- FSSNF has enhanced the Strengthening Ties and Empowering Parents (STEPS) program with the addition of a Health Care Coordinator and a Nurse Practitioner. Grant funded, the Healthcare Coordinator (HCC) is able to provide medical coordination through a newly augmented service array which includes a focus on medical consultation, domestic violence, and substance misuse. The Healthcare Coordinators are master level staff with either therapeutic or medical specialties. This enhanced service provision is designed to meet the following goals:
    - Providing access to, and improved quality of health care, for parent(s) and children
    - Increased numbers of children receiving developmental and social-emotional screenings and follow-up assessments and treatment services
    - Increased numbers of parents receiving health education/risk reduction training and demonstrating understanding and ability to successfully implement risk-reducing behaviors
- Partnership for Strong Families (PSF) teams with Meridian Behavioral Healthcare to maintain a pilot site for the Family Intensive Treatment Team (FITT) Model in Alachua County. This model is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. Treatment is available and provided in accordance with the indicated level of care required and service providers working under this model adhere to strict state guidelines regarding the program, which integrates treatment for substance abuse disorders, parenting interventions and therapeutic treatment for all family members (regardless of the payer for service) into one comprehensive treatment approach with the goal to engage families quicker and increase positive outcomes. Families referred into the program have a substance abuse disorder, at least one child under ten years old, have an open dependency case (can be judicial or non- judicial, in home or out of home) and be willing to participate in the program.
- PSF continues to participate in the statewide Model Courts Initiative in the implementation and improvement of parenting programs for our children in the dependency system. Two of PSFs providers completed the training for the Nurturing Parenting Program. Additionally, these two providers have staff trained by team lead, Dr. Lynn Katz (University of Miami), to complete behavioral observations on parents with children birth to five years of age. PSF has also implemented a parent readiness form used to help guide case management decisions around engaging in parenting services. The idea is to maximize the benefit from parenting services, while taking into consideration other factors within the family.

- During the review period, Community Partnership for Children completed a Trauma Informed Care project with the Chadwick Center for Children and Families and the Child and Adolescent Research Center (CASRC) located at Rady Children's Hospital- San Diego. All agency staff received training on the Trauma Tool Kit which focused on seven core concepts of maximizing physical and psychological safety for children and families, identifying trauma related needs of children and families, enhancing child and family well-being and resilience, enhancing the well-being and resilience of those working in the system, and partnering with youth, families and partner agencies. The local steering committee continues to meet monthly to discuss progress and future goals. This training is provided throughout the year for new staff, as part of our trauma informed care practices.
- Heartland participated in a Model Courts Initiative intended to bring evidence-based parenting practices into common usage across the child welfare system in the State of Florida. Heartland began engaging in a monthly consult call with Dr. Lynn Katz, of the University of Miami to help with developing plans and timelines for a full implementation of evidence based models of parenting curriculum. A local workgroup was formed consisting of the Circuit 10 Administrative Judge, The Honorable James Yancey, along with members from Children's Legal Services, the Department of Children and Families, the Guardian ad Litem Office and Regional Counsel. The statewide project ended as planned in March of 2016. During its existence, HFC played a primary role in assisting other CBCs with moving their evidence-based parenting initiatives forward.
- Brevard Family Partnership seeks to improve the safety, permanence, and well-being of children served by the child welfare system in Brevard County through the further integration of evidence-based and evidence informed practice in the community service delivery continuum. To assist in this effort and to conduct an assessment of the service delivery continuum and offer a practical roadmap to enhanced evidence-based service delivery, BFP contracted with Evidence Based Associates (EBA) in Charleston, South Carolina to organize the project in partnership with the Chadwick Center at Rady Children's Hospital in San Diego (RCHSD). The Chadwick Center together with the Child and Adolescent Services Research Center (CASRC) at RCHSD designed and manages the California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org) and has experience working with child welfare administrators in expanding the use of evidence-based practices. BFP used this roadmap to build capacity of promising practices by enhancing the current delivery system with the evidence based practices of the Nurturing Parenting Program, Child Parent Psychotherapy, Brief Strategic Family Therapy, and Cognitive Behavioral Therapy. Brevard C.A.R.E.S. h also entered into its second data validation study to achieve credentialing as an evidence based practice in the area of the prevention of future child maltreatment.
- BFP utilizes Child Parent Psychotherapy (CPP), a treatment for trauma-exposed children aged zero to five. Typically, the child is seen with his or her primary caregiver, and the dyad is the unit of treatment. CPP examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate deregulated behaviors and affect.

CPP directly provides services to children/adolescents and addresses the exposure to trauma, internalizing and externalizing symptoms, and/or symptoms of posttraumatic stress disorder (PTSD).

- In Brevard County, the Nurturing Parenting Program for Parents and their school age children five to 12 years is a 15-session program that is group-based and family-centered. Parents and their children attend separate groups that meet concurrently. Each session is scheduled for 2.5 hours with a 20-minute break in which parents and children get together and have fun. The lessons in the program are based on the known parenting behaviors that contribute to child maltreatment that include inappropriate parental expectations, parental lack of empathy in meeting the needs of their children, a strong belief in the use of corporal punishment, reversing parent-child family roles and oppressing children's power and independence. Assessment (pre, process, and post) of parent's parenting and child rearing beliefs, knowledge, and skills allows the program facilitators to measure the attainment of lesson competencies. The Nurturing Parenting Program and the Child Parenting Therapy programs are specifically designed for families with children ages five and under.
- In Circuit 6 new programs that are now in place are Early Childhood Court, Dependency Drug Court, and implementation of FITT service.
- In an effort to change the trajectory of young children entering out-of-home care, Eckerd Community Alternative in Circuit 6 has initiated Early Childhood Court in Pinellas and Pasco County. Early Childhood Court is a systems-change initiative, spearheaded by ZERO To THREE. It is modeled on the National Council of Juvenile and Family Court Judges Model Court Projects. Model Court judges focus on conducting their hearings in accordance with nationally recognized best practices. The Early Childhood Court Teams are led by judges who place a strong emphasis on addressing unique challenges facing infant and toddlers. The Early Childhood Team is focused on improving how courts, child welfare agencies, and related child serving organizations work together, share information, and expedites services for young children. This work increases knowledge among all those who work with maltreated children about the needs of infants and toddlers. At the local level, judges introduce the community to the Early Childhood Court approach. They collaborate with child development specialist to create teams of child welfare and health professionals, child advocates and community leaders. Together they provide services to abused and neglected infants and toddlers. An integral component of the Early Childhood Court initiative is the Icebreaker process for biological parents and foster parents. For qualified cases, Eckerd facilitates a meeting between the biological parent and the foster parent in order to encourage open communication, co-parenting, and information sharing about the child and the child's family.

  Early Childhood Court has two major goals:

  - Increase awareness among all those who work with maltreated infants and toddlers about the negative impact of abuse and neglect on very young children; and
  - Change local systems to improve outcomes and prevent future court involvement in the lives of very young children.
- As a part of time-limited reunification efforts, the Children's Network of Southwest Florida continues to partner with Cape Christian in Cape Coral to implement a specialized visitation program targeting children aged six months to five years old. The church has donated space for the visitations and has set up a clothing closet.

This year, the Children's Network of Southwest Florida has expanded the program by training licensing and visitation staff and locating additional sites to host the visits. The population served has been expanded as well. The concepts of the specialized visitation program are now a part of PRIDE training for prospective foster parents.

- Children's Network and Early Steps of Southwest (SW) Florida and Gulf Coast collaborated to develop referral protocols to ensure screening of at-risk children for developmental delays. All children from birth to age three determined to be victims of verified cases of child abuse or neglect and referred for on-going case management services are referred to Early Steps for an initial screening. If the results of the screening meet Early Steps eligibility requirements, an evaluation is completed with recommendations for on-going services to address the developmental delays.
- Children's Network of Southwest Florida works in partnership with the Early Learning Coalition of SW Florida and the Early Learning Coalition of Florida's Heartland to secure quality child care services for children in our dependency system. As a priority category of care, the Coalitions work with case managers and child protective investigators to refer children and families to child care centers and licensed family child care homes. This provides an additional level of safety for children in their own homes as well as to enhance child development, parent awareness, health screenings, and parent education for all caregivers, including foster families, relative and non-relative placements
- Circuit 12 participated in the initiative of the Office of Court Improvement to standardize and provide quality measurements and standards for parenting programs and outcomes. A Parenting Committee was in place and minimum standards for judicial cases to align program participation with permanency goals. Part of the Evidence Based Parenting also requires that parents who have children age five and under have Structured Observations occur. This adds a layer of validity to the parent having learned new skills from the programs and reduced the risk to the child.

  Structured Observation is a designed set of assessment tools developed to ensure the parental skill application of curriculum taught in community based parenting programs.
- The Safe Children Coalition (Sarasota YMCA) in Circuit 12 expanded to create a faith-based network of community providers (Believes Against Abused and Neglected Kids/God Raising Incredible Parents/Sanctuary Church) who have been trained as facilitators of the Nurturing Parent Curriculum and the Structured Observation tools. As non-traditional providers, the faith community has expanded service options to parents in county jails, local shelters and neighborhood community centers.
- Safe Children Coalition participated in Early Childhood Courts (ECC). Partnerships with the Florida Center for Child Development for Child Parent Psychotherapy, intensive structured observational/therapeutic visitation, intensive case management and other wraparound support for a parent that meets screen in criteria. Families involved with ECC have at least five visits a week with the child age three or under to continue to build the bonds. Contacts that the parent has in counseling, parenting, etc., with the toddler/infant can count toward those visitations. Assessment of application and engagement of services assists the team to determine how permanency decision making may be expedited.
- Devereux Families in Circuit 19 utilizes Behavior Basics and Refocusing the Modern Family where certified Behavior Analysts deliver applied behavior analysis services designed to promote positive and effective interactions for caregivers and victims of child maltreatment. Services are provided to Devereux CBC-referred dependent children with a mental health diagnosis. Services include

Behavioral Intervention Plans and caregiver training and support to implement the child's Behavioral Intervention Plan. Refocusing the Modern Family is a locally designed 12-week in-home parenting program conducted by Certified Behavior Analysts. Components include behavioral modification, proactive education, individualized family goals, applied support and role modeling to the entire family. Submitted to California clearinghouse for consideration as an evidence-based practice.

- Our Kids, Inc. in the Southern Region has a Clinical Program to manage the assessment and referral process for behavioral health services including mental health residential programs. Our Kids is committed to ensuring that emotional and behavioral problems of children entering the child welfare system are identified promptly, that services are initiated to meet each child's individual needs and that the quality of services is monitored continuously. In addition, the clinical department offers ongoing consultation and trainings to child welfare staff and community stakeholders.
- Specialized Therapeutic Foster Care (STFC) in Circuits 11 and 16 is a program designed to treat dependent children with one of more mental health diagnosis that have failed in regular foster or group home placements or have severe emotional or behavioral issues that require higher levels of treatment and supervision but do not meet criteria for residential treatment. The STFC homes provide a higher level of structure and treatment than your traditional foster homes and the parents have additional training to help the children stabilize and return to their permanency plan.
- Our Kids in Circuits 11 and 16 through the Children's Trust (the Trust) obtained funding for programs that offer the highest possible quality services with the goals of implementing best practices and improving the lives of children and families in our community. One such program is Early Childhood Development - Reaching children early and often with the services they need is a major focus for The Trust. Through a range of initiatives, we strive to ensure that, by the time a child enters kindergarten, he or she is prepared academically, socially, and emotionally. As part of this effort, our parenting programs support parents to be their child's "best" teacher.

Future Plans

The study of "Access, Integration of Care and Service Utilization for Child Welfare Involved Children in Florida's Managed Medical Assistance Program" included recommendations for improving the service array and access to services for all children. The Department will continue to collaborate with ACHA and the child welfare service providers to identify strategies and solutions for improving services to all children in child welfare, including the zero to five years of age population.

At the request of Secretary Mike Carroll, the Safety Practice Team within the Office of Child Welfare conducted an in-depth practice review of 30 child protective investigations conducted during SFY 2015-2016 involving substance exposed newborns. The 30 investigations were pulled randomly but with an intentional emphasis on reviewing Verified and Not Substantiated findings.

The multiple recommendations and issues identified in this review can be encapsulated into two major problems. First, many child protective investigators appear to lack sufficient training and knowledge regarding substance misuse in general, and more specifically, how child safety is compromised when a parent in either under the influence of a substance, or during the "rebound" period after use.

The second problem, is the failure of investigators to consistently consult with Family Intervention Specialists or other subject matter experts to inform the assessment of child safety during the investigations. While investigators often requested written treatment records on parents, investigators

rarely ever documented an actual conversation with current or former substance abuse treatment personnel.

In summary of the practice analysis conducted, child protective investigators need to take into account the totality of the information known on the family related to substance misuse. Significant criminal and child welfare histories related to drug use, multiple failed treatment admissions, and documented use of prescribed or illicit narcotics or other Schedule II drugs should inform decision making and service provision to the infants and families impacted by the effects of these powerful drugs.

As a result of changes in federal legislation and the guidance learned from the review of sample cases involving substance exposed newborns, the Departments Child Maltreatment Index (CFOP 170-4) was updated on December 23, 2016 as follows:

- Added a maltreatment specific to substance-exposed newborns.
- Enhanced the definition of substance-exposed newborn to more clearly articulate when parental substance abuse poses a threat of harm to young children.
- Provided additional guidance in Factors to Consider for the maltreatment.

Also updated was CFOP 170-5, Chapter 11, Substance Abuse Consultations. For the purposes of child protection assessment and interventions, it is important to accurately identify substance abuse disorders in order to determine child safety and inform parents of the comprehensive array of services available to achieve or maintain recovery. Out-of-control conditions in substance abusing families can be particularly challenging for investigators to assess because family and individual dynamics, such as denial and co-dependency issues, minimize if not outright deny that alcohol or substance misuse are problematic or are active in the family. These aspects associated with the dynamics of addiction emphasize the need for the investigator to consult with substance abuse professionals in order to assist in an accurate assessment and identification of any substance misuse or dependency problem.

The Department was selected to attend the 2017 Policy Academy: Improving outcomes for pregnant and postpartum women with opioid use disorders and their infants, families and caregivers.

The Department has identified a statewide leadership group to coordinate the multiple systems involved in the care of these infants and their families. Through this group ongoing policy review and revisions are occurring.

Included on the statewide leadership group are the Department of Children and Families Child Welfare and Substance Abuse and Mental Health, Department of Health, Agency for Health Care Administration, Healthy Families, Healthy Start, MIECHV, Florida Hospital Association, Early Steps, behavioral health care providers and associations, and the University of Florida.

As part of these group meetings, ways in which partner agencies can leverage internal policies and messaging are being maximized. The pathway and processes for notifications and response are being

explored. Florida's statewide work will incorporate the pre-pregnancy, pre-natal, and neonatal periods and the need of the mother, infant and family.

Planned for summer 2017 is a pilot project in the Tampa/Sarasota area, involving several of the hospitals in the area. Through this pilot we will explore the reporting of families to the Florida Abuse Hotline, thoroughness of the information reported, timeliness of reports being made, and the impact to workload for hotline and front line child protective investigators.

Following the completion of the pilot, we hope to have a picture of the impact to the Department and partner agencies. Through this pilot our hope is that infants and their families in need of services and support will be appropriately identified and served.

The Department will continue to work with Healthy Families Florida (HFF). HFF has a proven track record for preventing abuse and neglect. HFF provides tailored services to young children and their families. Eligible families share a number of risk factors that place their children at high risk of abuse or neglect. Families receive home visits that decrease in frequency as families make progress in providing safe, stable and nurturing environments for their children. Specifically-trained support workers help them improve their parenting skills and achieve goals that increase family stability and self-sufficiency.

Human Trafficking and Sexually Exploited Children

On a national level, DCF has partnered with multiple states to share information developed, lessons learned, and tools developed. Kansas and Kentucky asked Florida to discuss Florida's human trafficking response model. Numerous phone conferences occurred with Tennessee, Texas, North Carolina, Washington D.C. and California, to name a few, to share Florida's Human Trafficking Screening Tool (HTST) and to discuss the evolution of its response model. DCF held an initial call with southern region states to include Virginia, Georgia, North and South Carolina, Mississippi, Louisiana and Alabama to discuss their level of interest in creating a platform where states can share information, tools, policies and procedures developed to identify and responds to human trafficking. Florida is in the process of identifying the platform to be utilized since the states have indicated a desire to pursue a southern regional work group. Additionally, Florida representatives travelled to Minnesota and Georgia to learn about the centralized referral processes of these states and to learn of system strengths and challenges as Florida explores adoption of a similar structure. DCF hosted both Texas and Ontario, Canada for site visits throughout our continuum of care. The Department provided technical support to Washington, D.C. and Virginia child welfare agencies regarding Florida's response to the commercial sexual exploitation of minors. Florida also joined the Region IV, Administration for Children and Families Human Trafficking work group and continued work on the Shared Hope International, Expert Panel, drafting policy recommendations for national application.

Secretary Mike Carroll serves as the Vice Chair for the Florida Statewide Human Trafficking Council as well as chair of the Services and Resources Committee of the Statewide Council. The Council was created in 2014 by the Office of Attorney General, Department of Legal Affairs, and is led by the Florida Attorney General. The Council was created for the purpose of enhancing the development and coordination of state and local law enforcement and social services to combat commercial sexual exploitation as a form of human trafficking and to support victims. The Council consists of

- Attorney General,

- Secretary of the Department of Children and Families or designee,
- Secretary of Department of Juvenile Justice or designee,
- State Surgeon General or designee,
- the Secretary of Health Care Administration or designee,
- Executive Director of Law Enforcement or designee,
- Commissioner of Education or designee,
- one member of the Senate appointed by the President of the Senate,
- one member of the House of Representatives appointed by the Speaker of the House of Representatives,
- an elected Sheriff appointed by the Attorney General,
- an elected state attorney appointed by the Attorney General,
- two members appointed by the Governor, and
- two members appointed by the Attorney General, who have professional experience to assist the council in the development of care and treatment options for victims of human trafficking.

The Council provides recommendations through an annual report to the Legislature. The Services and Resources committee of the Statewide Human Trafficking Council is focused on the broad statewide continuum of care for youth and adult victims from prevention to placement and treatment and ending with transition and resiliency.

The DCF statewide human trafficking prevention director maintains close collaborative working relationship with counterparts from the Attorney General's Office, the Department of Juvenile Justice, the Department of Health, and the Department of Education. Collectively these agencies are building agency strategic plans in human trafficking prevention and a coordinated statewide response. Examples of collaborative projects include: creation of a 2016 human trafficking awareness training calendar across agencies; School human trafficking awareness poster project; evaluation of human trafficking as a public health issue with the University of Miami; and participation on the Interagency Council on Human Trafficking which develops the states strategic plan on human trafficking with Florida State University. In FFY 2016-2017, DCF provided agency strategic plan to Florida State University to update their statewide strategic plan for state agencies. The Department continued on-going trainings for a wide variety of state agencies, as well as DCF's child welfare staff. In addition, DCF human trafficking unit staff has coordinated with the United States Institute Against Human Trafficking (USAIHT) on the plan to open the first home for transgender juveniles CSEC victims in the nation. This has included connecting the entity with providers and experts in licensing, cultural competency, and service delivery for the LGBTQ community, as well as how to build capacity.

The Department participates on human trafficking task forces across the state. Currently there are task forces operating in all 20 circuits, some county level and some are regional task forces. These task forces address local or regional needs around education and awareness, legislative response, continuum of care and response, as well as county/circuit plans to respond to cases of human trafficking. DCF has participants on all task forces and takes a leadership role in a majority of these task forces. This allows for the DCF human trafficking unit personnel to have a true statewide understanding of the unique regional needs, flavor and responses, as well as recognizing gaps in continuum of care. This year we have

reenergized task forces in two areas and are scheduling a training symposium in the Northwest Region, where law enforcement and state attorneys report needing training to fully understand how to identify and respond to victims of human trafficking. In addition to the two rejuvenated task forces, DCF collaborated with a wide variety of state and locals partners in Pensacola and Panama City to launch task forces where they did not previously exist.

DCF utilizes a collaborative approach to address several of the challenges and needs in human trafficking identification and response mechanisms. As shared in the prior APSR, in 2014, DCF and DJJ facilitated two statewide workgroups: one which assisted in the development of the Human Trafficking Screening Tool (HTST) and one which assisted in the drafting of a statewide assessment of Florida's system of care regarding human trafficking, titled, "Restoring Our Kids." In 2015, the Department in partnership with Dr. Leslie Gavin, Nemours Children's Hospital, created a level of care placement tool; and partnered with Dr. Patricia Babcock with the Institute of Child Welfare at Florida State University to establish trigger criteria for initiating the use of the HTST. In 2015 and 2016, DCF spearheaded a statewide response to the clinical needs for human trafficking victims and system of care. The Department created five separate work groups, consisting of experts across the state, to complete five specific tasks to identify:

1. an assessment tool for adoption or creation;
2. the array of treatment interventions the state would like to approve for victims of commercial sexual exploitation;
3. metrics and outcomes for safe houses and safe foster homes;
4. a curriculum for mental health professionals treating human trafficking victims; and
5. a plan for leveraging the existing infrastructure of mental health and substance abuse providers rather than rely on the idea of building new infrastructure to treat human trafficking victims within their communities.

In addition, the Department created a residential provider work group and host bi annual meetings with providers who provide residential services to human trafficking victims. DCF also connect the residential providers with licensing and placement staff in regional offices and CBC lead agencies. Finally, there is a recognition of the need to engage survivor leadership in the development of policies and procedures in the area of human trafficking response, as well as strategic direction of next steps. As such, a volunteer advisory group comprised of Florida survivor leadership provide feedback to DCF on a variety of issues as requested. One example of an on-going conversation involves what is the role of survivor leadership in response to the human trafficking victim and what should engagement between child welfare and survivor leadership look like. From this conversation, the statewide human trafficking director and survivor leadership from The Wayne Foundation and More Too Life drafted a training on how child welfare and survivor leadership can partner to meet the needs of the youth. DCF has partnered with the new collaboration, Open Doors, to model a private public partnership. This entity will utilize state general revenue and Victim of Crime Act (VOCA) federal dollars to pilot a community wide response in five areas, providing intervention and placement for juvenile victims of human trafficking who are not under the jurisdiction of the Department or the Department of Juvenile Justice (DJJ). DCF has worked closely with Open Doors and DJJ to structure new work groups, expanding the work done by the original DCF clinical groups, as well as draft potential best practices for working with the population.

<u>Update/Accomplishments</u>

- Relaunched the Indian River human trafficking task force and assisted with focusing and strategizing the goals and purpose of the task force. DCF has taken leadership roles on the task force to ensure continued engagement and progress. The Pensacola and Panama City task forces were relaunched this year and after providing initial structure, DCF has worked to transition leadership to local entities. In addition, the Volusia County task force was rejuvenated through engagement by DCF with local organizations and leaders. Both the Indian River and Volusia County task forces are focused, energized and task oriented at this time. DCF will remain on the task force and continue to ensure engagement and progress.
- Created a volunteer advisory group comprised of Florida survivor leadership who provide feedback to DCF on a variety of issues as requested. This group remains in effect. The goal for 2016 – 2017 is to design and launch a survivor leadership group for youth 13 – 24. DCF has had contact with survivor leadership in Ontario, Canada who are facilitating a similar program and hope to gain technical assistance from them in creation of the group here. The intent is for youth to facilitate and lead the group. The Florida institute for Child Welfare has indicated they will provide therapist on site for the group meetings to respond to any needs that might arise.
- Published and made available statewide a 2016 training calendar for on-going quarterly certification training. Quarterly trainings included: Gang trafficking and Case Study, Survivor Panel, And Boys Too, and Blue Print for Human Trafficking. DCF completed the training series, highlighting the Blue Print for Human Trafficking training at DCF's annual child welfare conference, as well as at the Family Focused Treatment Association (FFTA) and the Florida Sex Crime Investigators Conference.
- Submitted the revised 2014 Restoring Our Kids report by September 30, 2016 to the Services and Resources Committee of the Statewide Human Trafficking Council. The updated report also includes adults in the continuum of care. This report evaluates existing services, identifies gaps in the continuum of care, as well as discusses scope and scalability. The report details recommendations to the state for next steps. The 2016 Council of Human Trafficking, Services and Resources Committee's annual report was submitted to the Attorney General's office and, subsequently, the Florida Legislature on October 1, 2016. This paper identified next steps, to include an implementation plan.
- Partnered with the Guardian ad Litem (GAL) Program on the development of GAL human trafficking response units. This development will occur over the next three years. The Guardian ad Litem (GAL) withdrew from the application for VOCA funding to create this program. DCF continues to engage with the GAL program and invite staff to any training held by DCF on human trafficking.
- Continued working on expansion of the specialized therapeutic safe house model, which is showing promising practice through independent analysis by USF. This includes connecting providers with community based lead agencies to pursue federal grants for potential expansion. Expansion of funding was identified as a need in the 2016 Council of Human Trafficking, Services and Resources Committee's annual report. The report recommendations should be pursued by the Legislative and Special Initiatives committee of the statewide council.
- Work with the Statewide Human Trafficking Council to identify a centralized referral process. This includes evaluating private public partnerships as a structure for potential implementation. Florida representatives visited Minnesota and Georgia to evaluate their structures and are in conversation with Texas. Open Doors was funded to build a private public partnership and will utilize state general revenue and VOCA federal dollars to pilot a community wide response in five areas, providing intervention and placement for juvenile victims of human trafficking who are not under the

jurisdiction of DCF or DJJ. This is the first step in the creation of a centralized funding stream and a centralized referral and assessment process.

- Held a regional symposium in Northwest Region for child welfare, law enforcement, and state attorneys in Pensacola to increase knowledge and awareness of human trafficking, as well as provide mentoring opportunities from detective and state attorneys who have experience working human trafficking cases. This was an initial community step to build a foundation of knowledge around the topic of human trafficking for first responders.
- Implemented the Human Trafficking bills, passed during the 2016 Legislative Session, that went into effect on October 1, 2016:
    - HB 545 – Human Trafficking: removes persons under the age of 18 from prosecution for prostitution, and makes correlating changes in Chapter 39, F.S., relating to the definition of the term "sexual abuse of a child," to reflect that sexually exploiting a child in prostitution should be viewed as human trafficking.
    - HB 1333 – Sexual Offenders: amends a variety of statutes to align with the federal Adam Walsh Act; removes language that currently prevents a parent or guardian from being designated as a sexual predator or offender when he or she has been convicted of a specified kidnapping, false imprisonment, or luring or enticing a child offense against his or her minor child.

Future Plans

- Implement the recommendations from the 2016 Services and Resources Committee annual report and draft a synopsis of efforts to that effect for the 2017 annual report.
- Increase the child welfare and substance abuse integration regarding the identification, response, and restoration of victims of human trafficking.
- Four of the five workgroups provided full deliverables by December 1, 2016. The mental health curriculum work group provided a partial product. DCF has worked with DJJ and Open Doors to identify next steps for all of the work completed in the clinical work groups. Collaboratively, the entities have drafted new work groups with expanded goals and identified the participation lists for each. This will be an ongoing project as Open Doors structures and designs their service delivery and then through implementation of that plan.
- Continue work with the Managing Entities, Community-based Care lead agencies, and Medicaid providers to identify clear pathways to obtain specialized treatment for victims of human trafficking.
- Work with Our Kids in Miami and Community-based Care lead agencies in the Suncoast Region to identify ways to provide more integrated, victim-centered practice for pregnant and parenting CSEC youth in DCF care.
- Become more culturally competent around LGBTQ victims of sex trafficking as a system of care, as there has been increased identification of transgendered youth as victims.
- Continue to work with the Institute of Child Welfare through Florida State University to modify the Human Trafficking Screening Tool (HTST) created through DCF and DJJ collaboration.
- The Statewide Council on Human Trafficking and the Service and Resources committee of the Council, published annual reports to the legislature in October 2016. These reports detail trending in prevalence, funding, identification, placement and restoration services for adults and minors

throughout the state of Florida. The report includes recommendations for next steps for all three subcommittees: Services and Resources, Legislative and Special Projects, as well as the Law Enforcement committee. Included in the report is an implementation plan, with agency assignments for those activities assigned to the Services and Resources committee.

Quality Parenting Initiative

In 2013, the Florida Legislature enacted the Quality Parenting Initiative (QPI) in an effort to improve child safety, permanency and well-being for children who are placed in Florida's out-of-home care system. QPI is designed ensure that children are residing in an out-of-home care setting with a caregiver who:

- has the ability to care for the child,
- is willing to accept responsibility for providing care, and
- is willing and able to learn about and be respectful of the child's culture, religion and ethnicity, special physical or psychological needs, any circumstances unique to the child, and family relationships.

QPI is one of Florida's approaches to strengthening foster care, including kinship care. It is a process designed to help a site develop new strategies and practices, rather than imposing upon it a predetermined set of "best practices."

Update/Accomplishments

- All but two (2) of Florida's CBCs were actively participating in the Quality Parenting Initiative which involves ongoing technical assistance, as well as special initiatives.
- Strategic partnership with QPI and CBCs on a number of initiatives, including:
  - Streamlining licensing requirements;
  - Revising the normalcy policies for foster parents;
  - Coordinating with the Secretary's Priority of Effort collaborative tasked improving recruitment & retention of foster homes for teens, and children with special needs;
- Completion of the Year Two work plan for the Federal Intelligent Recruitment Project (FIRP) included the following activities:
  - Project team members for the diligent recruitment grant built organizational capacity within individual CBCs to assure appropriate staffing as outlined by the project.
  - Team members began implementation of customized marketing plans developed through a stratified marketing and recruitment approach based on data gathered from the in-depth strategic questionnaire for each or the FIRP service areas.
  - Team members focused their work on the revision of data collection tools, foster parent surveys, year 2-5 work plan tasks, marketing plans, home study processes and licensure timeframes, evaluation, and coordination of FIRP integration with QPI. The partners continued to refine expectations, measure progress and improve communication within the project team. Deliverables included, Updated marketing plans, Dissemination plan, Inquiry and Recruitment Tracking Log, and Work Plan Status and Updates.

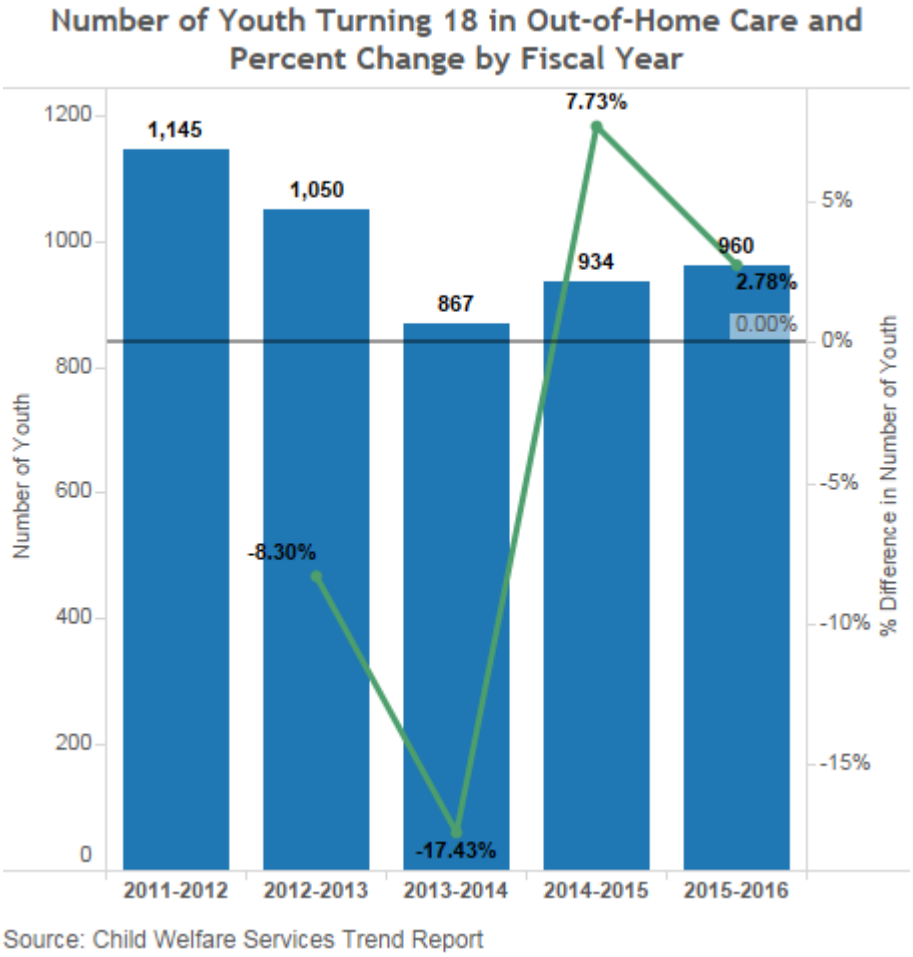
- Implemented chapters within operating procedure 170-11 related to Normalcy effective 7/25/2016. These include:
  - Chapter 6, Normalcy,
  - Chapter 7, Babysitting, and
  - Chapter 8, Vacation and Out of Town Travel.

Future Plans

- Work in collaboration with QPI to facilitate a workgroup focused on analyzing and improving the process for foster parent investigations.
- Work with the Florida Institute for Child Welfare on the development of the Group Care Quality Standards Assessment Tool. The Florida Institute for Child Welfare will pilot the tool and will implement statewide to assess for the Group Care Quality Standards.
- Seek technical assistance from National Resource Center for Diligent Recruitment to develop a customer service model.
- Analyze the use of concurrent case planning and compare to federal expectations as part of the FIRP project. This activity is expected to result in recommendations regarding policy changes to DCF.
- Coordinate and participate in the Federal Project Officer's site visit to assess the progress Florida has made in the Intelligent Recruitment Project.

Independent Living

In Florida, 955 youth aged out of the foster care system in calendar year 2016. The chart below depicts five years of data by state fiscal year (SFY). Without taking into account the status of legal custody or placement type at the time of discharge, the report includes 18-year-olds who have aged out of foster care. Although the number of young adults exiting out-of-home care at 18 decreased between 2011 and 2014, the number of young adult exiting care began increasing in SFY 2014/15. In SFY 2015/16, 26 more youth exited out-of-home care than in SFY 2014/15.



Source: Child Welfare Services Trend Report

As set forth in statute, four categories of independent living services are currently available in Florida for young adults ages 18-23, including:

- Extended Foster Care (EFC)
- Postsecondary Education Services and Support (PESS)
- Aftercare Support Services
- Road-to-Independence Program

Detail on the array of services is in Chapter IX, John H. Chafee Foster Care Independence Program (CFCIP) and Education and Training Vouchers (ETV). The following are brief descriptions of the programs available to eligible former foster youth.

Extended Foster Care (EFC)

EFC gives eligible young adults the option of remaining in foster care until the age of 21 or until the age of 22 if they have a qualifying disability. By implementing EFC, Florida allowed for a more structured system

of transition services for the young person entering adulthood. Young adults may decide to remain in their licensed foster homes or choose other supportive living environments with approval of their Community-based Care lead agency (CBC) while finishing secondary school or adult education, or entering the workforce. Eligible young adults may also choose this option while pursuing postsecondary education. In EFC, young adults receive standard case management visits, case planning, transition planning, monitoring of life skills development, and judicial oversight as required. Florida's EFC is state funded; state funds pay room and board and may pay for other allowable expenses, such as child care for young adults who are parenting, clothing for work or school, computer and other school supplies, and other essential services needed to support the young adult's transition.

Postsecondary Education Services and Support (PESS)

Eligible young adults 18-22 (not yet 23) years of age in PESS receive $1,256 per month and other supports necessary to become self-sufficient. After the initial application process, eligibility requires that these students are enrolled in nine credit hours or the vocational equivalent; and if meeting academic progress according to the Florida Bright Futures educational institution, the students may continue to receive the assistance. Some exceptions to credit hours and progress may apply for those students with a diagnosed disability or other recognized challenging circumstance. Of the three independent living services categories, PESS is the only program that affords youth who are adopted or placed with court-approved dependency guardians after the age of 16 with the opportunity to participate. The law requires those youth to have spent at least six months in licensed care within the 12 months immediately preceding such placement or adoption. Education and Training Voucher (ETV) and Chafee Foster Care Independence Program (CFCIP) federal funds cover room and board and other expenses necessary to pay the cost of attendance.

Aftercare Services

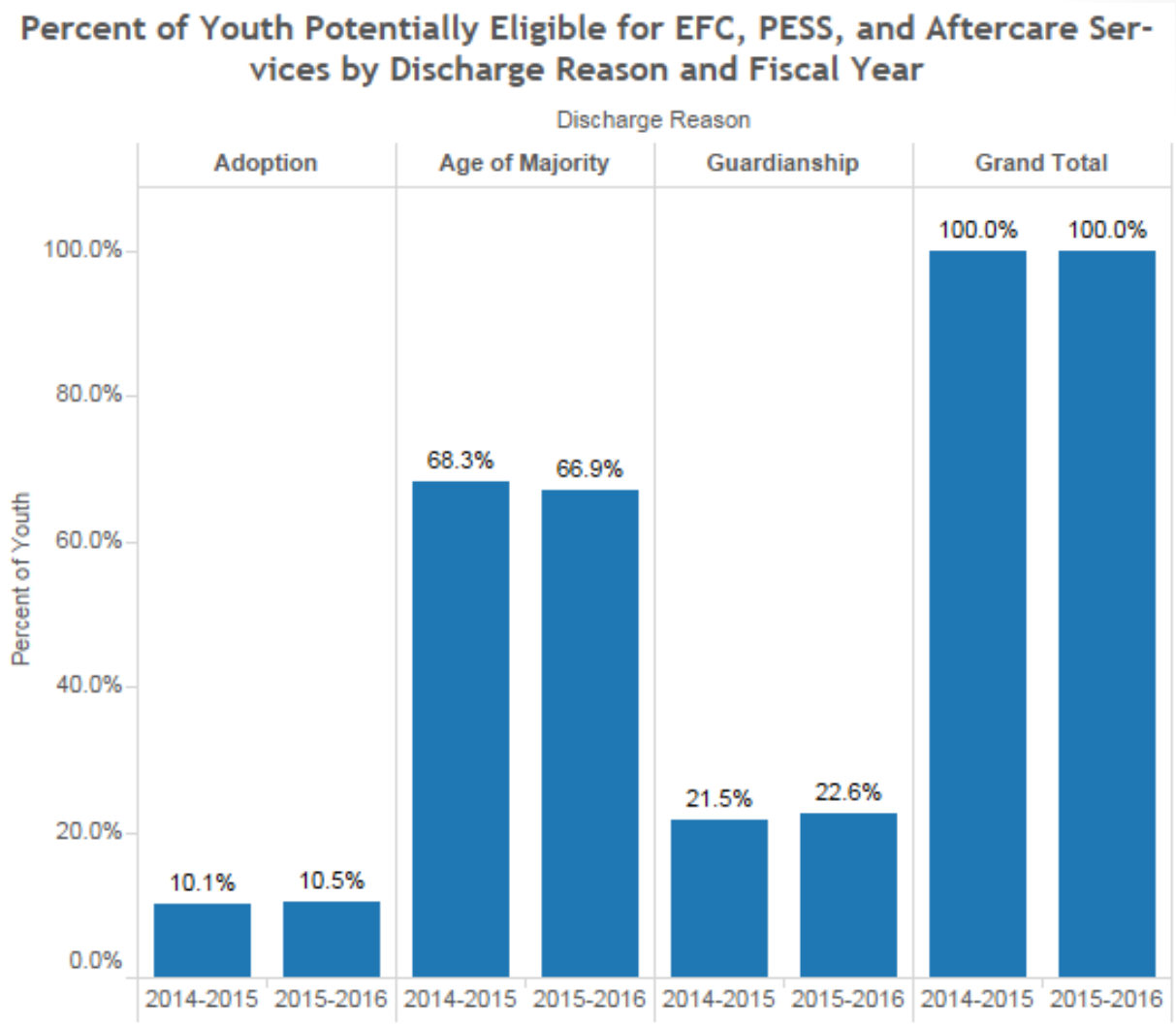
To be eligible for Aftercare Services, a young adult must have reached the age of 18 while in the legal custody of the Department, but not yet have turned 23. Aftercare Services are intended to be temporary in nature or used as a bridge into or between EFC and PESS. Services may include mentoring, tutoring, mental health, substance abuse, counseling, and financial assistance. Both federal and state funds are available to pay for allowable expenses.

Road to Independence (RTI)

Although this program has not been available to new applicants since changes to Florida Statute in 2014, there remains a small population of young adults served through RTI grandfathered into the program. These youth, assessed at each renewal period, receive RTI benefits until no longer eligible. PESS replaced the former "Road to Independence" program, as authorized in section 409.1451, Florida Statutes.

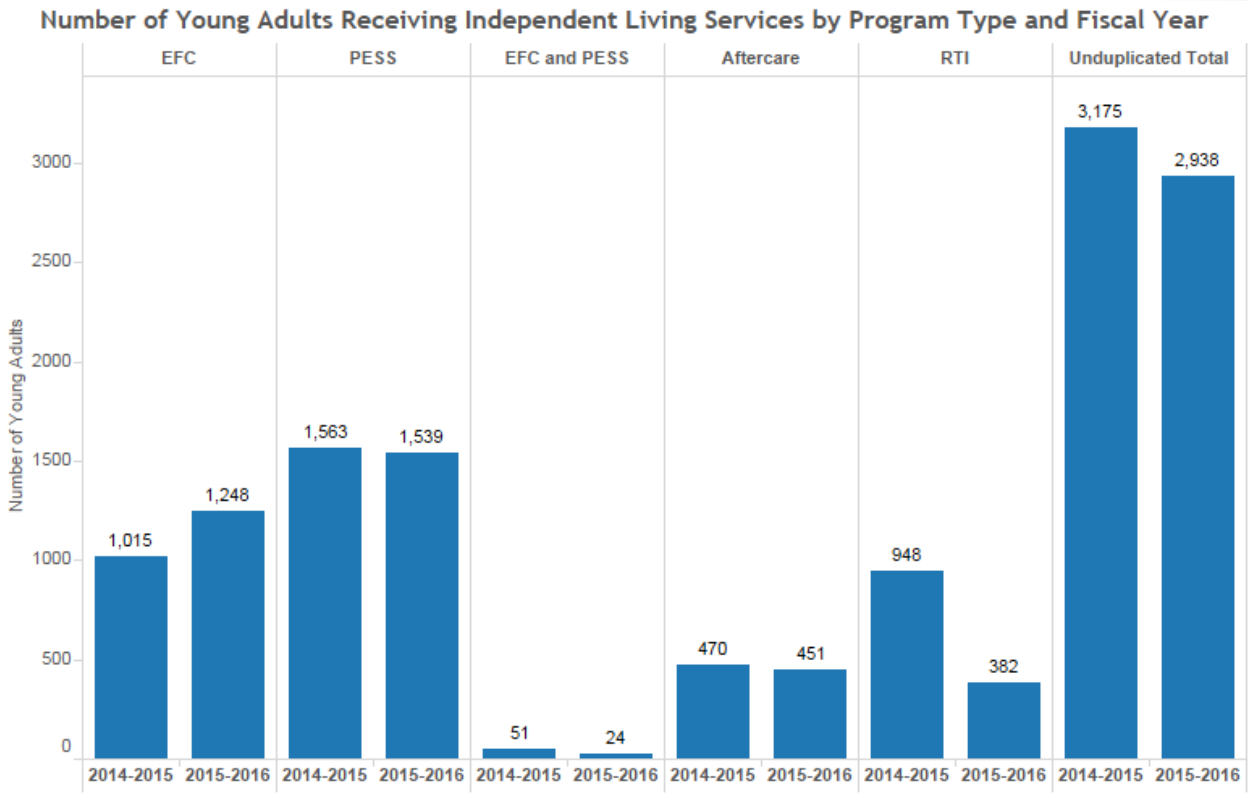
Youth Potentially Eligible For and Young Adults Receiving Independent Living Services

The chart below depicts the percentage of youth ages 16, 17, and 18 who are or will be potentially eligible for EFC, PESS, or Aftercare Services by discharge reason. Since each program is unique in its eligibility, young adults may be eligible for one program but not the other. In SFY 2015-2016, 65 more youth were potentially eligible for services compared to SFY 2014-2015. Each discharge category showed an increase in youth.



Data Source: OCW Data Reporting Unit, Regularly Scheduled Report #1682

The bar chart below illustrates the number of young adults who received an independent living service, by program, and in total, between the reporting periods. To be counted in this report, a young adult must have received an independent living service payment generated through Florida Safe Families Network (FSFN), the statewide automated child welfare information system. The number of young adults served by EFC increased by 233 from SFY 2014-2015 to SFY 2015-2016. The number of young adults in PESS and Aftercare Services declined in the same time period. Some young adults may have received more than one service type in a particular year; therefore, a count reflecting an unduplicated total is also shown. Overall, there were 237 fewer young adults participating in independent living services in SFY 2015-2016 than in SFY 2014-2015.



Source: FSFN OCWDRU #1173

Update/Accomplishments

- Program updates are discussed throughout Chapter IX, John H. Chafee Foster Care Independence Program (CFCIP) and Education and Training Vouchers (ETV).

Future Plans

Future plans are discussed throughout Chapter IX, John H. Chafee Foster Care Independence Program (CFCIP) and Education and Training Vouchers (ETV).

Education Information and Service Integration

The Department along with various educational partners, the Department of Education, local school boards, post-secondary institutions, foster parents and caregivers, continued to work together toward common goals for educating children, youth and young adults.

Florida continued its work to develop an infrastructure to measure the accomplishments and needs of children in out-of-home care. Information gathered will aid Florida's child welfare partners in creating policies and projects to enhance children's educational success in all phases of education, including post-secondary.

The Department participates in several workgroups and committees within the Department of Education, including the State Secondary Transition Interagency Committee for students with disabilities and the Project AWARE State Management Team for student mental health services. Additionally, the Department collaborates with the Bureau of Exceptional Education and Student Services to host quarterly conference calls with the School District Foster Care Liaisons throughout the state.

Update/Accomplishments

- The Department continued to work with Casey Family Programs to improve data sharing between school districts and Community-based Care organizations.
- The Department continued working with the Florida Department of Education as well as other state agencies to update the Interagency Agreement to Coordinate Services for Children Served by the Florida Child Welfare System.

Future Plans

- Revise the Guide to Improve Educational Opportunities to include Every Students Succeeds Act (ESSA) requirements and best practices.
- Establish Community-based Care lead agency points of contact and local school district points of contact to enhance collaboration and communication.
- Create a school stability checklist to be used by local Community-based Care lead agencies and local school district to assist in determining school placements for children in out-of-home care.

Adoption

Community-based Care lead agencies (CBCs) are responsible for identifying and reporting to the court the permanency options available to each child removed from a parent or legal guardian. The scope of case management services includes reunification of children with parents or arranging for adoption or guardianship when reunification is determined by the court not in the best interest of a child. CBCs are responsible for pre- and post-adoption services including the provision of maintenance adoption subsidies.

Pre-Adoption Services. Pre-adoption services include, at a minimum, mental health services to prepare children for adoption, legal services to sever the parental rights in order for a child to be legally free for adoption, supervision of visitations between siblings and other birth family members, and supervision of adoptive placements for a minimum of 90 days. Services for prospective adoptive parents include the provision of adoptive parent training and the home study process.

Recruitment of Adoptive Families. The majority of children adopted from the child welfare system are adopted by the families known to the children and in areas where they were already living by their foster parents or relative or non-relative caregivers. For remaining children, new families must be identified and recruited.

One of the major initiatives Florida uses to recruit adoptive families is the Explore Adoption campaign and associated website. Explore Adoption is a statewide adoption initiative aimed at promoting the benefits of public adoption. Explore Adoption urges families to consider creating or expanding their families by

adopting a child who is older, has special needs, or is a part of a sibling group. Through public education, expanded partnerships and social media, Explore Adoption invites Floridians to learn more about the children immediately available for adoption in their home state and community. The initiative puts a new face on public adoption by telling many stories of families who have enriched their lives by adopting Florida's children.

Post-adoption Services. The Department has placed an increasing emphasis on the provision of post-adoption supports to families in order to sustain successes for forever families. Services include post adoption communication program, support groups, adoption competency specialists and training, and post-adoption services counselors.

Post Adoption Communication

Child welfare professionals designated by the CBC are required to make contact with adoptive families, by phone, one year after finalization of adoption in an effort to provide on-going post adoption support and services.

Support Groups

Adoptive parent and youth support groups provide opportunities for adoptive parents and youth to meet with other adoptive parents and youth who are struggling with similar challenges and concerns. These groups generally meet once a month and are appropriate for the languages, cultures, and needs of the participants in each community; receive support from umbrella organizations and qualified facilitators when appropriate (e.g., teen support groups); etc. In the rural areas where there are limited numbers of adoptive families, newsletters and group emails are being utilized to provide new information about post adoption services and provide an avenue for adoptive families to communicate with each other.

Over 25,000 children have been adopted from Florida's child welfare system in the last eight years. Research has shown that essential to family resilience are social connections, knowledge of parenting and of child and youth development, parental resilience, and concrete support in times of need. All of these can be made available to families through adoptive parent support groups. The post adoption services counselors are connected to one of the support groups in their area and assist with providing local community resource persons as speakers for one or more of the support group meetings during the year. Each teen support group has an adoption competent mental health professional facilitating.

Adoption Competency

Adoption competent mental health professionals have completed the Rutgers Adoption Competency or an equivalent curriculum approved by the Department of Children and Families to provide educational and therapeutic services for adoptive families. The educational and therapeutic services focus on strengthening relationships within the family unit and assist families in understanding the developmental stages of adoption, and how adoption affects each family member and the family as a unit.

To incentivize mental health professionals to attend the Adoption Competency Training, the Department has provided, at no cost to the trainees, Certified Educational Units (CEUs) for each mental health professional continued licensure.

Post Adoption Services Counselors

A post adoption services counselor is a staff person designated to respond to the requests and service needs of adoptive parents and their families after adoption finalization. The response to requests and service needs should include, at a minimum, information and referrals with local resources, assistance to child protective investigators when an investigation involves an adoptive parent, temporary case management, assistance with subsidy and Medicaid issues and assistance in establishing and maintaining one or more adoptive parent support groups. All post adoption services staff assist child protective investigators when an investigation involves an adoptive family. The post adoption services counselor assesses the needs and potential services for the adopted child and adoptive family.

With over 25,000 children adopted from foster care during the last eight years, one or more designated post adoption services counselors in each circuit are critical for responding timely to the service needs of adoptive families. The State of Florida and its partners are committed to providing a sufficient and accessible array of post adoption services in each circuit that includes information and referral services, temporary case management, assistance with assessments during investigations, assistance with subsidy and Medicaid issues, and assistance in maintaining one or more adoptive parent support groups for the many adoptive families who face significant challenges as their adoptive children age and experience the various developmental milestones.

Inter-country Adoptions. The number of private adoption agencies in Florida that complete inter-country adoptions has declined. Currently, there are approximately 14 private agencies, an increase from the six private agencies reported for the previous year.

The Department of Children and Families does not monitor the number of inter-country adoptions completed. If the child of an international adoption is determined to have special needs according to Florida's definition of special needs, the adoptive family would be eligible for post-adoption services provided by the staff of the lead agencies.

When a child from an international adoption removed due to abuse, abandonment or neglect, the child and family receive the services in order to help the child and family remain safe; and services are provided to assist with reunification efforts. The CBCs self-report these numbers to the Department and the Department annually assesses the types of maltreatments and statuses of these cases. The Department receives two to three reports of international adoptees removed due to abuse, abandonment or neglect per year. Due to infrequency of such reports, the Department does not plan actions beyond the annual assessment and follow-up, but will continue to monitor these reports for any increase in frequency.

Adoption Incentive Award. Florida has received an Adoption Incentive Award for each of the last seven years. The incentive award payments assist with Florida's significant maintenance adoption subsidy budget. During State Fiscal Year 2015/16, an estimated 36,000 adopted children received maintenance adoption subsidies with the average subsidy of $4,820 annually. The Department anticipates continuing net increases in subsidy costs over the next several years, for two reasons:

1) approximately 1,300 children age out and no longer require subsidies each year; new families adopting and needing subsidy will greatly outnumber this decrease, and

2) the Florida legislature approved an increase in subsidy amount for new subsidy recipients several years ago; therefore the average amount of subsidy will gradually increase.

To meet this expanding need, any future incentive funds will continue to be applied toward subsidies. Adoption Incentive Awards are incorporated into the CBC Schedule of Funds allotments for each CBC contract. The Department's Revenue Management office, each CBC contract manager, and the Lead Agency Fiscal Unit within the Administrative Services office all monitor expenditure of these funds and provide oversight toward timely, accurate, and fiscally responsible management of resources. There are no plans to modify the expenditure of adoption incentive funds.

Update/Accomplishments

- Developed requirements for the recruitment of foster homes and mentors for children placed in out-of-home care for One Church One Child.
- Emphasized during regularly scheduled calls with adoption specialists the importance of accurate and timely data entry into FSFN.
- Created an Adoption Competency Curriculum work group to review and update the current curriculum used in training mental health professionals, adoption case management, and other stakeholders. Individuals from the CBCs and private adoption agencies created sub-groups to review and update curriculum. Interim stop-gap curriculum was created until the updated Adoption Competency Curriculum is developed.
- Developed and implemented the Child Welfare Operating Procedure, 170-12, Adoption, effective 3/18/2016. The operating procedure provides guidance on post communication and the Community-based Care Adoption Incentive Program

Future Plans

- Collaborate and explore with Dave Thomas Foundation's Wendy's Wonderful Kids program increasing the number of adoption recruitment grants across the state. Wendy's management is interested in increasing the number of grants and will be meeting with the Department to discuss the possibility of expansion in Florida.
- Continue updating the Adoption Competency Curriculum.
- Develop Annual Adoption Award to recognize one or more individuals, families, or organizations that make significant contributions to enabling children in foster care to achieve permanency through adoption.
- Update Operating Procedure, 170-12, Adoption, to include the yearly adoption targets, CBC Adoption Incentive Program, and Adult Adoption policy and procedures.

Interstate Compact On the Placement of Children (ICPC)

The Interstate Compact on the Placement of Children (ICPC) ensures protection and services to children placed across state lines. The need for a compact to regulate the interstate movement of children was recognized over 40 years ago. Since then the Department has worked with the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) to address identified areas of concern within the Interstate Compact such as the time it takes to place children in the dependency system in safe homes across interstate lines.

The ICPC office collaborates with our partners, other states, and stakeholders. The use of lead ICPC liaisons within individual CBCs allows a single point of contact for both the CBC and the ICPC office, which streamlines communication and increases the efficiency of the ICPC process. The office collaborates with the regions through monthly conference calls, quarterly face-to-face meetings, through use of the Interstate Compact System (ICS), and through daily emails. Additionally, the Compact Administrator participates in the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) and currently services as the association's vice president. The Compact Administrator attends the annual AAICPC conference and serves on various committees within the organization, allowing for the establishment and maintenance of relationships with ICPC central office staff as well as local staff from other states. The Compact Administrator also attends conferences and presents at meetings with both private and public sector partners throughout the year.

The Compact Administrator works with CLS, case managers, and representatives from other states on difficult cases, and often facilitates conference calls between Florida workers and other states to ensure positive outcomes for children. Additionally, the Florida ICPC office provides presentations as needed to the Children's Legal Services attorneys, judiciary, Guardians Ad Litem, Attorneys Ad Litem, case managers, supervisors, licensed social workers, investigators and ICPC liaisons at Community-Based Care Lead Agencies. Furthermore, the Compact Administrator works closely with CLS and members of the judiciary, participating in meetings and presentations throughout the year.

Modernization of the ICPC processes is an ongoing technology effort. The ICPC processing system within the State of Florida began a conversion to electronic transmittal and web based data transmission in the spring of 2008. The goal of the modernization project was to eliminate transmittal of paper ICPC files through the mail, reduce the number of persons who handle a file, and shorten the time spent in the approval process. The assignment of cases by state resulted in personal relationships being developed between Florida ICPC specialists and their counterparts in other states. Staff has also gained additional knowledge of the laws and regulations of their assigned states.

ICPC modernization converted the existing tracking system to a paperless file system. The process now scans all incoming and outgoing documents and creates various data entry screens to capture and store information on each case. One of the best features of the system is the generation of automatic e-mail reminders and notices for critical dates in the ICPC process. Additionally, the system includes a feature that allows a case specialist who is in receipt of a new case to determine if the child's records are present in FSFN and, if so, to extract the child's demographic information and import it into the Interstate Compact System (ICS).

The system database, accessed by the courts, Community-based Care lead agencies, Guardians Ad Litem, and department attorneys, allows view of the master ICPC file and case status. This transparency has improved the quality of ICPC work and significantly reduced the time it takes to process a case within the State of Florida.

Florida's ICS system served as the basis for the National Electronic Interstate Compact Enterprise (NEICE), a national web-based program through which states can exchange ICPC cases and information. Florida served as one of the six pilot states for the NEICE system in 2014 and served as part of the technical advisory team on the project. The results of the pilot showed a significant decrease in processing time for

ICPC cases and nationwide implementation began in June 2015, with the ultimate goal of onboarding all states by 2018.

Update/Accomplishments

- Continued to be a part of the NEICE Project and serve on the technical team of the project. Florida assisted APHSA and AAICPC in the national implementation effort. Additionally, Florida supports further development and enhancement of the NEICE system.
- Proceeded in discussions with Alabama surrounding creation of a border agreement for processing ICPC cases between the states. Such an agreement would provide a method for each state to provide placement approval in expedited timeframes and allow children to reach permanency faster.
- Provided ICPC trainings throughout the state to the judiciary, Guardians ad Litem, Department attorneys, protective investigators, Community-Based Care agency staff, and other interested stakeholders.

Future Plans

- Continue to be a part of the NEICE Project and serve on the technical team of the project. Florida will continue assisting APHSA and the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) in the national implementation effort. Additionally, Florida will continue to support further development and enhancement of the NEICE system.
- Continue discussions with Alabama surrounding creation of a border agreement for processing ICPC cases between the states.
- Continue to offer ICPC trainings throughout the state to the judiciary, Guardians ad Litem, Department attorneys, protective investigators, CBC staff, and other interested stakeholders.
- Continue to serve on the executive committee of AAICPC to assist with addressing national ICPC issues.

Information System

The Florida Safe Families Network (FSFN) is the state's automated official case management record for all children and families receiving child welfare services, from screening for child abuse and neglect at the Florida Abuse Hotline through adoption. FSFN provides opportunities to identify child welfare outcomes and practices and ensure a complete record of each child's current and historical child welfare information.

The Department continued to collaborate with all stakeholders and contracted providers. One example of collaboration includes FSFN System Adoption Initiative site visits and development of FSFN Utilization Papers. Other examples of ongoing collaboration include defining build content for system improvements, defining and validating functional requirements, and designing the system improvements for Post-Adoption Support enhancements.

Update/Accomplishments

- Implemented the release of Post-Adoption Support enhancements to FSFN on April 1, 2016. The major goal of these enhancements was to increase support to adoptive families by providing and

documenting post-adoption services and to provide a more consistent approach to the delivery of adoption services, including recruitment and intervention services for post-adoptive families.

Specific enhancements included functionality to:

- Document services requested, referred and provided;
- Document contacts with adoptive families following adoption finalization;
- Document the expressed interest of a family to adopt; and
- Provide reporting capabilities.

- Developed a plan for transitioning the FSFN system to the cloud. The plan was completed and submitted to the Legislature, which subsequently included a $4 million allocation in the state fiscal year 2016-2017 General Appropriations Act to support moving FSFN to the cloud. Amendment 10 with IBM, the FSFN system integrator, supported the cloud project by funding some of the work necessary to upgrade software to the latest supported versions in preparation for moving to the cloud.
- Concluded the FSFN System Adoption project in September 2016; the project team completed on-site technology assessments with each Sheriff's Office conducting child protective investigations and each CBC lead agency in order to identify gaps in system support of business processes and the cause of these identified gaps. Additionally, the team assessed data migration needs, policy clarification or guidance needs, and completed reviews of 86% of FSFN utilization Position Papers. The results of these activities indicated that statewide strategic solutions are required rather than individualized CBC solutions. This was due to the surfacing of some common themes, such as inconsistent understanding of the practice model and how FSFN supports it, varied FSFN utilization among the CBCs, and inconsistent notification of changes in practice and supporting FSFN functionality (i.e., communications not "reaching the field").

Future Plans

- Modify FSFN to align more fully with enhancements to Florida's child welfare practice model. The proposed enhancements aim to create efficicencies in instances where FSFN current design requires "work-arounds" or manual processes to complete required workflow. The proposed enhancements also incorporate better data reporting functions and enhancements to the FSFN Reporting environments that will advance the CBCs' ability to track and monitor practice model implementation and further advance the Department's Results-Oriented Accountability Program.

  Specific FSFN builds to support enhancements to Florida's Practice Model include:

  - Child Protective Investigations: changes to Safety Determinations and Safety Plans, Family Functioning Assessments wherein a child is deceased due to alleged abuse or neglect, "Other" investigations (those that are neither In-Home nor Institutional) and the use of Patently Unfounded and/or False Report determinations;
  - Intakes, Child Protective Investigations, and Case Management: additional practice model tools for CBC case managers (Family Functiong Assessment-Ongoing, Progress Update, Safety Plan, Judicial Review Worksheet, Case Plan); a new Child Receiving Services real-time listing which allows immediate access to individual caseloads and efficient management of key milestones such as assessments due, court hearings, medicial and dental appointments, permanency goals,

etc.; the alignment of maltreatments to those in the current Child Maltreatment Index, to include substance-exposed newborn, household violence threatens child, intimate partner violence threatens child and failure to thrive/malnutrition/ dehydration; and improvements to aid in both child protective investigator and CBC case manager efficiencies, including improved organization of assessment information for each person record, added display information which enables assessment indentification and access from both Search and the FSFN desktop, and a new Case Plan Task summary to assist case managers and family members with the timely identification of task details and progress.

- Child Placement Agreement and FSFN Data Reporting: a new tool to support the creation and management of plans to support Care Precautions and Behavioral Management plans during child placements and a new universe within the FSFN Business Objects Environment to enable CBCs to access data related to the Practice Model implementation.

Child Maltreatment Death Reporting

Florida's source of reporting child maltreatment deaths for National Child Abuse and Neglect Data System (NCANDS) reporting is the SACWIS system, Florida Safe Families Network (FSFN). Florida remains committed to reducing the number of child deaths due to maltreatment, particularly when the victim has been involved with the child welfare system.

Update/Accomplishments

- Continued to analyze the qualitative data derived in Qualtrics and, in conjunction with recommendations from the CIRRT advisory committee, will use the findings to further enhance our system of care.
- Provided quarterly analysis to leadership depicting any patterns/trends with regard to child fatality investigations received on families known to the Department compared to families not known to the Department.
- Collaborated with regional specialists to begin planning training initiatives focused on the child fatality investigative process and prevention strategies in which families and local communities can be engaged. Regional specialists then implemented content-specific training to investigators with regard to the investigative changes and enhancements.

Future Plans

Expand the quarterly analysis of child fatality information to compare causal factors between those involving families known to the Department to those involving families not known to the Department to ascertain what, if any, differentiation exists.

Promoting Safe and Stable Families

The "Promoting Safe and Stable Families" program assists the Department in achieving CFSP Goal Area A: Enhance family-centered practice with an emphasis on child safety, permanency, well-being, and trauma-informed care and Goal Area C: Expand and refine the service array to ensure it reflects evidenced-based, best or emerging practices about child development and family functioning. To increase parents' confidence and competence in their parenting abilities and to ensure children a safe, stable and supportive family environment is a top priority for Florida. The "Promoting Safe and Stable Families" program allows the Department to develop, expand, and operate coordinated programs of community-based services.

As in all aspects of social services, particularly child welfare, an integrated and collaborative approach with multiple partners and stakeholders is essential. Florida's child welfare professionals use a safety-focused, family centered and trauma informed approach. Florida's lead agencies work closely with subcontracted providers to administer training and technical assistance related to funding criteria and rules, which result in collaborative and notable use of resources.

Creating positive change for Florida's children and families is only possible when all of the organizations involved with Child Welfare recognize their individual and collective roles in enhancing the safety, permanency and well-being of those served. In Florida, the key Child Welfare stakeholders and partners include the Department of Children and Families (DCF, the Department), Community-based Care lead agencies (CBCs, lead agencies), communities, providers, contractors, other state agencies, Tribes and the judiciary. Collectively, these stakeholders represent the Florida Child Welfare Community (Child Welfare Community).

The unique partnerships within Florida's child welfare community create opportunities for long-term improvement by bringing together many perspectives and experiences with a singular focus on improving the lives and safety of each child in Florida.

By taking a more complete view of all entities charged with responsibility of achieving the statutory outcomes specified in s. 409.986(2), F.S., establishing appropriately defined outcome measures, measuring and analyzing the results, assigning corresponding accountability and connecting results with actions, Florida has the platform to fundamentally shape policy and create innovative practices. The program will allow the child welfare community to take a long-term view, and to confirm with research and evidence the interventions used are efficacious and effective in realizing positive outcomes for children.

Results-Oriented Accountability intends to allow all of the stakeholders in the Child Welfare Community to identify and to manage their contributions to the achievement of outcomes for children and their families. The Results-Oriented Accountability Program creates a framework for measuring the success of efforts to improve Child Welfare outcomes, while creating a culture of transparency and accountability.

Given the importance of preventing child abuse and neglect and the wide range of programs and strategies available, the Department continues to invest in a continuum of prevention services. The Department strives to prevent child abuse and neglect statewide through its community-based care approach, contracts and partnerships with notable experts in the fields of primary, secondary and tertiary prevention programs and strategies.

Through family support, family preservation, time-limited reunification, and adoption services, the Department continues to serve vulnerable children and families. The Department continues its determined interest in ensuring the success of new and existing child abuse prevention programs.

These initiatives, policies and practices are all in a concerted effort to reach goals set and embraced by the professionals who make up Florida's child welfare community:

- Florida's children live free of maltreatment.
- Florida's children enjoy long-term, secure relationships within strong families and communities.
- Florida's children are physically and emotionally healthy, and socially competent.
- Florida's families' nurture, protect, and meet the needs of their children, and are well integrated into their communities.

Family Preservation Services (29% of the FFY 2016 Grant)

Florida continues to optimize the efforts toward families (including adoptive and extended families) at risk of separation, or facing difficult circumstances by performing the following duties, including:

- Information and referral to include substance abuse and domestic violence related services[3];
- Targeting services geographically in zip codes where there is an increased need.
- Use of the Family Team Conferencing Model[4];
- Creation of the Clinical Response Teams[5];
- Home safety and maintenance activities
- Use of Wraparound services[6].

Family Support Services (26% of FFY 2016 Grant)

Family support services are intended to prevent the occurrence of a future child abuse investigation and/or child maltreatment by: Strengthening protective factors that will increase the ability of families to nurture their children successfully; Enhancing the social and emotional well-being of each child and the family; Enabling families to use other resources and opportunities available in the community; Assisting families with creating or strengthening family resource networks to enhance and support childrearing. This support is to encourage and assure the complete safety and well-being of children and families.

While there are many examples of typical supportive programs to families, Florida has readily embraced:

3 Activities that provide families with needed information about community and statewide services and agencies that provide specific services and if necessary, provide referral information.

4 Service providers and families come together as critical partners/members of the team where consensus is established and a coordinated plan is developed and adhered to by all parties.

5 Healthy visitation, role modeling, parenting skills are encouraged and enforced to promote a healing and healthy growth towards the parent/child relationship.

6 Community mandated service design where local providers "un-bundle" previously categorical services to families thereby allowing families to receive individualized services for a period of time necessary.

- *Pinwheels for Prevention™,* the Child Abuse Prevention Month Public Awareness Campaign *(*Prevent Child Abuse Florida's Child Abuse Prevention Month statewide campaign) and various other public awareness campaigns designed to increase the protective factors necessary for the well-being of both children and their families;
- parenting classes geared toward various developmental ages and stages and the effects of family violence and substance abuse on children;
- health and nutrition education training sessions;
- home visiting activities and services;
- comprehensive family assessments;
- early developmental screening of children to assess needs, and assistance to families in securing specific services to meet those needs;
- in-home parent training;
- in-home substance abuse counseling;
- information and referral to community resources, such as job employment services and ACCESS Florida (for online benefits applications).

Time-Limited Family Reunification Services (21% of the FFY 2016 Grant)

Time-Limited Reunification services are put in place for children removed from his/her home and for the parents or primary caregivers. Florida passionately embraces these services, because of our desire to maintain intact families. These services are designed to support the reunification of a child safely and appropriately within a 12-15 month period.

Time-Limited Family Reunification Services in Florida include:

- Supervised visitation programs and parental coaching[5];
- Flexible Support Services[6];
- Family team Conferencing[7] with all families prior to reunification, and just before post-placement supervision services are successfully terminated;
- Follow-up care to families[8];
- Mentoring/Tutoring services[9];

5 Healthy visitation, role modeling, parenting skills are encouraged and enforced to promote a healing and healthy growth towards the parent/child relationship.

6 Community mandated service design where local providers "un-bundle" previously categorical services to families thereby allowing families to receive individualized services for a period of time necessary.

7 Prevention/Reunification Specialists facilitate meetings. These conferences are made available to families referred under the prevention referral process.

8 Activities include weekly home visits to discuss parenting and communication issues as well as specific strengths and challenges to the family.

9 Activities provided to children to enhance their self-esteem, self-confidence, and provide a positive adult role model. Tutoring allows the child to obtain additional educational support and training.

- Therapeutic child care services; and
- Parent (adoptive, biological, caretaker, foster) education and training[10] relationship skill building activities.

Adoption Promotion and Support Services (23% of the FFY 2016 Grant)

In Florida, the Adoption Promotion and Support Services have served a major role in the adoption of children from the foster care system. These adoptive homes are carefully chosen to ensure it is in the best interest of the child. Pre and Post adoptive services and activities have quickened the process and closely supported adoptive families to forefend disruptions. The adoption of foster children continues to be a state, as well as a local effort.

Examples of *Adoption Promotion* include:

- Child-specific or targeted population recruitment efforts;
- Quarterly matching events for children available for adoption and potential families;
- Heart Galleries[11];
- Child Recruitment Biographies[12];
- Child-specific or targeted population recruitment efforts;
- Use of social media;
- Media blitzes targeting severely medically fragile available children; and
- Town hall meetings and "Lunch and Learn" activities

Examples of *Support Services* include:

- Collaboration with Early Learning Coalitions;
- Home and school visitation with post-adoptive families and children;
- Adoptive parent support groups[13];
- Counseling referrals;
- Post-adoption specialists;

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10 Parent education services are culturally sensitive. Parenting training is provided through educational groups and/or individual sessions. Parenting skills training provided to teach/promote appropriate discipline, anger management, child development and age appropriate behaviors, parent-child communication, self-punishment using role playing and modeling of appropriate parental behavior. Parenting training is provided through educational groups and/or individual sessions.

11 Traveling photographic exhibit created to find forever families for children in foster care.

12 Child Recruitment Biographies continue to be one component utilized for attracting families. In an effort to accurately describe the available children so that families can make an informed decision on whether their strengths can meet the child's needs, recruitment biographies are updated on an ongoing/as needed basis for all children.

13 Activities related to creating new adoptive and foster parent support groups and supporting and maintaining existing parent support groups. The support groups seek to reduce the social isolation of families by developing a peer support network.

- Individual and family counseling for adopted children and/or family members (must be of 12 month duration or less);
- Adoption workshops/seminars for adopted children and their families and professionals on topics relevant to ongoing issues facing adoptive families;
- Ongoing parent education and training opportunities for adoptive families; and
- Follow-up support services and liaison to adoptive families[14].

Community Facilitation and Innovative Practices

Child maltreatment prevention services usually fall under a banner that includes; public awareness activities, skill based curricula for children, parent education programs and vigorous support.

Recognizing that when the Department, CBC lead agencies, and many partners such as faith based organizations, civic groups and business partners collaborate and provide family centered practices, this can make a difference in efforts to preserve Florida's families by protecting children. Several innovative practices listed below illustrate the state's commitment.

- **Directions for Living, Family Works Program** is based on a foundation that is built around the client and their needs. Each case is staffed through an integrated decision making model. The family is encouraged to bring any part of their support system. Decisions regarding risk, treatment plan, visitation and closure are made through this team with the family being the significant source of information. There are standing subject matter experts that share in the integrated decision making process along with the various agencies involved with the family. Cases are staffed every fifteen days.
- **Gulfcoast Safe at Home Wraparound Program (SAH)** is a short-term, intensive, in-home community based program serving families where children are at imminent risk for removal from their homes. The major goal of the Safe at Home Program is to keep children safe and prevent families from entering the child welfare dependency system. The program provides the necessary clinical services and case management to strengthen the families' ability to maintain family safety, support and stabilization with the aid of family, friends and community. The team provides therapeutic interventions that target family stabilization to those challenged with substance abuse, family violence, child abuse and neglect, lack of parenting skills among many other challenges. Upon completion of services, families are expected to be empowered, have a great ability to problem solve and access community resources to help them face future challenges.
- **Family Reunification Team (FRT)** provides services to families recently reunified with their children, FRT provides rapid on-site response including 24/7 and weekend on call. FRT Therapists provide family, couples and individual counseling; anger management; behavior modification; hands on parenting instruction specific to the family's needs; sobriety maintenance, relapse prevention and substance abuse treatment; domestic violence services including survivor counseling.

14 Lead agencies designate staff whose sole responsibility is to work with families who need assistance after their adoption is finalized. Staff attempt to locate resources within the community for pre- and post-adoptive families to meet both the child's and family's needs.

- **Partnership for Strong Families, Community Resource Centers** have seen great success. Partnership for Strong Families now has three resource centers with a fourth center planned. Each of the centers that PSF operates are a collaborative effort along with other entities including Casey Family Programs, Alachua County Library District, the Florida Department of Children and Families, the Southwest Advocacy Group, the City of Gainesville, Tri-County Community Resources and the City of Chiefland. Each of the resource centers use an innovative approach to neighborhood engagement which encourages the involvement of all community members, parents, local government, schools, businesses, public and private agencies. The community members jointly identify and achieve mutual goals and objectives for serving at-risk communities.
- **Florida Coalition Against Domestic Violence FCADV)** Child Welfare and Child Protection Initiative projects are a collaborative effort between FCADV, the Office of the Attorney General, the Department of Children and Families, local Certified Domestic Violence Centers, Community-based Care agencies, and other child welfare professionals, implemented to provide an optimal coordinated community response to families experiencing the co-occurrence of domestic violence and child abuse. After years of partnership, the DCF Domestic Violence Program Office and FCADV possess a clear understanding that early involvement of domestic violence advocates in cases where child abuse and domestic violence co-occur can reduce the risk to children by providing immediate resource and referral information and safety planning for the non-offending parent and their children. FCADV's Child Protection Initiative Project establishes partnerships in which a domestic violence and child welfare advocate is co-located within a child protection investigation unit. The co-located advocate provides consultation to child protection staff, referral services to survivors, and attends monthly meetings between all partnering stakeholders to develop strategies to resolve any barriers or issues that may arise. The ultimate goal of these projects is to bridge the gap between child welfare and domestic violence service providers to enhance family safety, create permanency for children, and hold perpetrators accountable for their actions.

Administration (0% of the FFY 2016 Grant)

Includes the costs of in-home and out-of-home "community facilitation services" that are not provided through contributions from state and local sources. These services are defined in Title IV-B of the Social Security Act, Section 431 as the costs associated with developing, revising and implementing and coordinating the comprehensive Child and Family Services Plan/Promoting Safe and Stable Families five-year plan.

The table on this page displays the specific details regarding the differences between the estimated and actual grant award.

FFY 2016 Title IV-B Part II, PSSF	FFY 2016 Estimated Award*	% of Est. Award	Actual Expend as of 9/30/16**	% of Actual Expenditures	Difference
Family Preservation	$4,983,753	28%	$ 4,741,327	29%	2%
Family Support	$4,526,171	25%	$ 4,180.614	26%	1%
Time Limited Family Reunification	$3,993,931	22%	$ 3,432,967	21%	-1%
Adoption Promotion & Support	$4,528,820	25%	$ 3,774,494	23%	-2%
Administration	$ -	0%	$ -	0.00%	0%
Actual Total Award	**$18,032,675**	**100%**	**$ 16,129,402**	**100%**	**0%**

***CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services (APSR, June 2016)

**Includes FFY 2015 and FFY 2016 federal grant award expenditures.

Chapter III. Florida's Assessment of Performance

The round three Child and Family Services Review (CFSR) is the state's most recent assessment of performance. The CFSR final report, posted on Florida's Center for Child Welfare, is located at the following link:
http://centerforchildwelfare.fmhi.usf.edu/qa/CFSRTools/2016%20CFSR%20Final%20Report.pdf.

To address the findings in the final CFSR report, the Department in collaboration with stakeholders from across the state, developed and submitted Florida's Program Improvement Plan (PIP). Refer to Chapter IV for improvement goals, strategies, and key activities.

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CHAPTER IV. Florida's Plan for Improvement

Overview

The findings from Florida's Child and Family Services Report (CFSR) 2016 final report provided the foundation for this update. The Child Welfare Task Force has the responsibility to lead, guide, direct, and advise the statewide implementation of major initiatives. One such major initiative is implementation of Florida's Program Improvement Plan (PIP). The Task Force oversees the implementation of Florida's Program Improvement Plan (PIP) in addition to other responsibilities.

Florida's Child Welfare Practice Model forms the organizing structure within which Florida child welfare is approaching the complex task of pursuing improvements and moving toward a vision of all children living in a safe, stable and permanent home, sustained by nurturing relationships and strong community connections. The four major goal areas of the Practice Model (safety, permanency, child well-being, and family well-being) are directly related to the national outcome domains for child welfare (safety, permanency, and well-being) as defined through the Child and Family Services Review (CFSR) process. The goals and improvements align with the findings identified in Florida's CFSR 2016 final report and Florida's PIP. This update focuses on the activities and tasks during the APSR report period including the integration of goals, strategies, and key activities within Florida's PIP. Refer to Florida's PIP for detail. http://centerforchildwelfare.fmhi.usf.edu/CFSRHome.shtml

- Goal 1: Children are first and foremost protected from abuse and neglect; safely maintained in their homes, if possible and appropriate; and provided services to protect and prevent removal from their homes.
- Goal 2: Children have permanency and stability in their living situations and the continuity of family relationships and connections is preserved for children.
- Goal 3: Families have enhanced capacity to provide for their children's needs, and the well-being of children is improved through services to meet their education, physical health and mental health needs.

The CFSR also defines seven systemic factors that are crucial causal elements for driving results. The systemic factors are:

- Statewide Information System
- Case Review System
- Quality Assurance System
- Staff and Provider Training
- Service Array and Resource Development
- Agency Responsiveness to the Community
- Foster and Adoptive Parent Licensing, Recruitment, and Retention

The Summary Matrix, Attachment A to Chapter IV, summarizes the goals, measures, objectives, benchmarks, and activities. The Summary matrix delineates the progress made during the report year.

GOALS AND STRATEGIES

This chapter contains the revised goals and strategies that align with Florida's Program Improvement Plan (PIP). In addition to incorporating the goals, strategies, and key activities from Florida's Program Improvement Plan (PIP), this report also provides a year three update on the relevant objectives, strategies, and targeted activities for improving child welfare per the CFSP 2015-2019, Chapter V.

Goal 1

Children are first and foremost protected from abuse and neglect; safely maintained in their homes, if possible and appropriate; and provided services to protect and prevent removal from their homes.

Florida Performance

Safety Outcome 1 Performance on National Standard Measures

MEASURES	FY 2014-15	Lower Risk Standardized Performance	Risk Standardized Performance	Upper Risk Standardized Performance
Recurrence of Maltreatment (National Performance – 9.5%)	Not met	10.4%	10.7%	11.1%
Maltreatment in Foster Care (National Performance – 8.5%)	Not met	13.22%	14.22%	15.29%

Source: Florida's CFSR Data Profile dated May 2017

The presenting issues for investigations into child safety in Florida confirm that addressing child safety is a complex area related to other social ills, particularly mental health, substance abuse, and domestic violence. The massive size of the task in Florida and the intricate interrelationship of demographic factors, such as the age or race of children likely to become victims, are further reasons for continuing to make child safety a priority.

In addition to identifying and investigating instances where children are potential victims of child maltreatment, taking action to offset or prevent such harm is also critical. Preventing child maltreatment, particularly for the youngest and most vulnerable, is important for reducing harm to children in the short term (injury, fatality, removal from the family, etc.).

GOAL 1:

Strategy A. Strengthen and Enhance Florida's Child Welfare Practice Model. This strategy affects child safety through increased analysis and the child welfare professional's ability to identify, assess, and make decisions about potentially unsafe children.

There are two key activities to address child welfare professional's accountability for commencement of investigation.

1. Strengthen accountability for commencement of investigations and proper case documentation.

2. Implement amended operating procedure, CFOP 170-5, Child Protective Investigations, which strengthens statewide guidance related to diligent attempts to make face-to-face contact with alleged child victims of an investigation

Strategy B. Improve families' ability to provide for their own and their children's needs through quality family assessments, family engagement, and appropriate supports to address identified needs. Through family engagement it is anticipated that the quality of assessments will improve and more closely align with case planning. This will result in the child being safer and caregiver protective capacities enhanced.

The key activities to address family engagement and quality of assessments are:

1. Further develop child welfare professionals' skills, knowledge, and abilities relating to safety planning, safety plan management and family assessments through "back-to-basics" in-service training of the Child Welfare Practice Model.
2. Conduct black belt project to identify root causes of maltreatment in out-of-home care and identify recommendation(s) for statewide implementation.
3. Conduct black belt project to identify root causes of re-entry into out-of-home care and identify recommendation(s) for statewide implementation.
4. Implement CFOP 170-7, Develop and Manage Safety Plans, related to development and management of safety plans to further guide child welfare professionals on safety management.
5. Continue to support implementation of Safe Babies Court Teams at the 18 sites throughout the state and track select parallel data elements of the Safe Babies Court to Florida's PIP measures for comparison and possible replication.
6. Request legislative appropriation to enhance availability of safety management services statewide.

YEAR THREE UPDATE:

The progress made over the report period regarding the objectives, strategies, and targeted activities (CFSP 2015-2019, Chapter V) to improve safety decisions to ensure children are not re-abused or re-neglected is below. The strategies and targeted activities under Goal 1 address increased safety and expanded protection for children involved in child welfare.

1. Continued implementation of the Child Welfare (Safety) Practice Model.
2. Utilization of Secondary Case Reviews and Rapid Safety Feedback to assess safety practices of child protective investigators.
3. Implementation of the Safe Harbor Act

A summary of the strategies and year three update for targeted activities follows:

1. <u>Continued implementation of the Child Welfare Safety Practice Model</u>

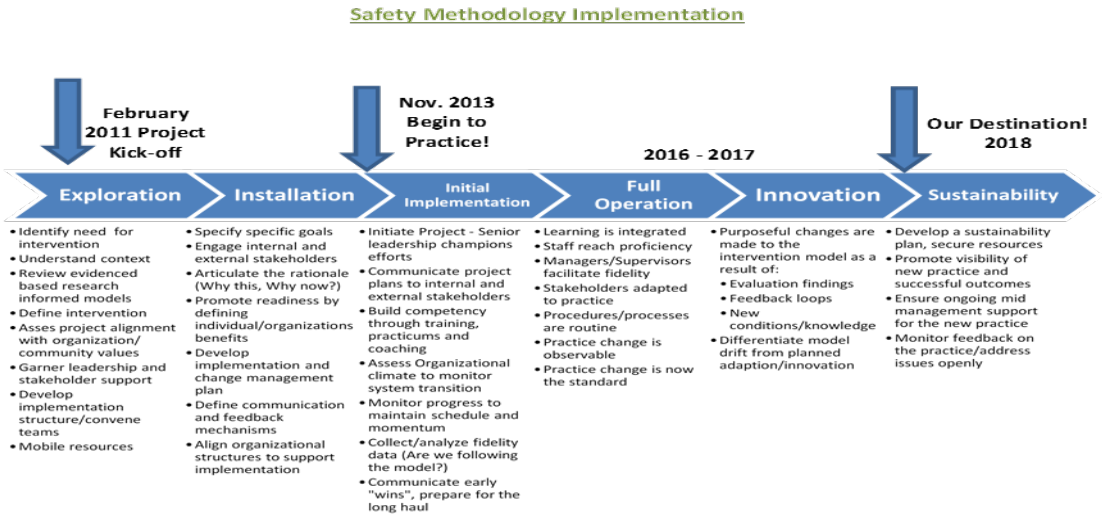
The Department is transforming the way that it conceptualizes and executes its mission by reengineering, transforming, and improving the capabilities of staff, operational processes, and supporting technologies. The Office of Child Welfare (OCW) provides leadership and supports coordination among all of the major implementation providers. At the heart of the change is the child welfare practice model, which began implementation in 2013. The child welfare practice model is Florida's integrated approach to:

- Initial identification of potentially unsafe children by the Florida Abuse Hotline;
- Further assessment of safety and safety decision making by investigators;
- Ongoing safety management and service provision to enhance parental protective capacities (emotional, cognitive and behavioral), address and enhance child well-being needs (emotional, behavioral, developmental, academic, relationships, physical health, cultural identity, substance abuse awareness, and adult living skills); and
- Providing a framework for safe reunification (conditions for return) or decision-making points for other needed permanency options by case managers.

The implementation of Florida's child welfare practice model remained the primary focus for the Department of Children and Families. Using implementation drivers, Florida continued the journey through initial implementation focusing on skill building and staff development, using data and continuous quality improvement to further model fidelity, operationalizing the practice through policy and guidance, supporting the practice through leadership and SACWIS system functionality.

The implementation of the child welfare practice model is a multi-year journey through transformation that requires the commitment of leadership and incorporates all of the identified implementation drivers to achieve our goal of safety, permanency, and well-being for all of Florida's Children for whom we serve. The illustration below depicts the timeline for implementation activities

Practice (Safety) Model Implementation



The Department has implemented and is working toward full implementation of the child welfare practice model with Child Protective Investigations.

The CBC and case management organizations (CMO) in Florida are continuing to progress in implementation as well. The family functioning assessment (FFA) is the first practice process/tool completed after case transfer to ongoing case management. As of March 15, 2017, 65.8% of the cases under CBC supervision had and approved FFA – Ongoing.

Targeted Activity: Continued implementation of the Child Welfare Practice Model.

During this report period, implementation of Florida's child welfare practice has remained a focus for the Department of Children and Families. Using implementation drivers, the Department continued the journey through initial implementation focusing on skill building and staff development, using data and continuous quality improvement to further model fidelity, operationalizing the practice through policy and guidance, supporting the practice through leadership and SACWIS functionality. The Department reached full implementation for investigations in February 2016; implementation continues with ongoing case management.

2. Utilization of Secondary Case Reviews and Rapid Safety Feedback to assess safety practices of child protective investigators.

The Department's Continuous Quality Improvement processes include Rapid Safety Feedback (RSF) case reviews for child protective investigations (CPI). These reviews play a major role in Florida's established child welfare system's CQI/QA process (see Appendix A, CQI). Rapid Safety Feedback is a case review process that targets open investigations of children under the age of 4 where there is at least one prior investigation on any member of the household and the current allegation is for substance misuse and

family violence threatens harm. Research has uncovered a number of risk factors or attributes commonly associated with the probability of experiencing maltreatment in households with these factors. The RSF review consists of immediate case consultations via a decision support team within ten days of the intake to ensure accurate assessment of present danger and support upfront safety decisions. The case review occurs again at thirty days to strengthen the safety decisions and assessments made while the investigation is still open.

Rapid Safety Feedback case reviews target open investigations because this affords an opportunity to identify activities that need attention before making final decisions and closing an investigation. Immediate child safety concerns are documented on the Request for Action screen in FSFN for all secondary case reviewers. Critical Child Safety Practice Expert (CCSPE) reviewers use the Rapid Safety Feedback Supervisory Consultation Module in FSFN to capture concerns, identify a worker for notification, and prevent the case closure. The procedure requires an Operations Manager review and confirm all safety issues are resolved.

A key component of the system is the "rapid feedback" case consultation. This requires the QA staff to provide coaching to CPI Supervisors and CPIs through a consultative process designed to encourage critical thinking and help improve skills related to the identification of present and impending danger threats, safety planning and management, information collection, assessment, and decision-making. Though coaching and mentoring have long been a part of the CQI loop facilitated by the Department's CQI/QA system, Rapid Safety Feedback is a systematic and focused method to make an immediate difference in both investigator and supervisor skill sets, and immediate course correction to insure each case reviewed is on track.

Reviews are conducted using the Rapid Feedback QA Review document that provides the overarching review items, core concepts, and guidelines:

- Prior Child Abuse and Neglect Reports, Prior Services, and Criminal History: Are the prior child abuse and neglect reports, prior services, and the criminal history information obtained timely, accurately summarized, and used to assess patterns, potential danger threats, and the impact on child safety?
- Information Collection: Is sufficient information collected and validated?
- Identification of Danger Threats and Assessment of Caregiver Protective Capacity: Are danger threats or safety concerns accurately identified and caregiver protective capacities sufficiently analyzed to determine the caregivers' ability to control the identified danger threat or safety concern?
- Safety Planning: Is the Safety Plan viable and does it incorporate safety strategies implemented in response to an identified danger threat or safety concern?
- Supervisory Case Consultation and Guidance:
    - Is the CPI supervisor providing consultation, support, and guidance to ensure sufficient information is collected to support a quality assessment and appropriate decision making?
    - Has the supervisor assisted the investigator in identifying a pattern of child maltreatment that takes into account the history of reports/investigations, and not just the current allegation?

- Is needed ongoing supervisory consultation and guidance provided?
- Are issues identified by the supervisor resolved timely?

For the Rapid Safety Feedback process, the Department reviews approximately 2,880 open cases each year. The sample is selected using the business objects report entitled "The Daily Child Investigations and Special Conditions Listing V4MK" and is available within the FSFN Ad Hoc Shared Folder>Ad Hoc Investigations Status Folder. The report was developed to default to the profile needed for the QA sample selection but can be expanded for other uses by regional managers. The default profile includes all children under the age of four where the following is present:

(a) Parent or caregiver of any age;

(b) At least one prior report was received on the victim child or other victim child under the age of four (0 to 3 years and 364 days) or caregiver within the household;

(c) The active investigation contains the alleged maltreatments of family violence threatens harm and substance misuse; and

(d) The investigation is open not less than 25 days and not more than 35 days.

As described above, the Rapid Safety Feedback reviews are part of the systematic Continuous Quality Improvement (CQI) process designed to provide data around child protective investigation activities, as well as to provide immediate skill and knowledge development for investigators and supervisors in the most critical issues for the most vulnerable population. The feedback loop for RSF case reviews include face-to-face and video teleconference meetings with regional staff and quality assurance staff across the state.

The Department continued the proficiency process for QA staff members designated as CCSPEs. These staff members must be experts in Florida's child welfare practice model in order to provide the correct guidance to CPIs and supervisors. The CCSPE proficiency process has four steps including tests at each juncture. Action for Child Protection reviews written reports and observes consultations for testing. Failure to complete a step after two attempts results in the staff's transfer to another position. The proficiency steps are described below:

- **Step 1: Must receive an overall passing score on a randomly selected Rapid Safety Feedback Review.** This assessment will evaluate the Reviewer's competencies and professional behaviors as demonstrated through the written analysis documented in a completed Rapid Safety Feedback investigation.
- **Step 2: Successful demonstration of feedback and consultation skills.** The reviewer will be observed (telephonically) providing feedback to a CPI and supervisor during a randomly selected consultation. To achieve proficiency, the reviewer must be able to articulate and convey goal focused feedback with "Practice Model" concepts/constructs.
- **Step 3: Reviewer will demonstrate the ability to lead fidelity case consultation calls.** The reviewer will be observed (telephonically) leading a randomly selected statewide fidelity call. To achieve proficiency, the reviewer must be able to demonstrate the application of practice model concepts/constructs and assist the field with identification of barriers and challenges.

- **Step 4: Reviewer will demonstrate the ability to train the new practice.** The reviewer will be observed leading/training one 2-3 hour learning circle for frontline staff related to gaps identified through analysis of local secondary/rapid safety feedback reviews.

The attainment of proficiency ensures QA staff members are highly skilled experts in the practice model. QA staff members are a strong support to the CPI and supervisor due to the collaborative approach of the consultation process.

Targeted Activity: Utilization of Secondary Case Reviews and Rapid Safety Feedback to assess safety practices of child protective investigators. Ongoing.

The Department's RSF open case review process continues to strengthen case review collaboration between the CPI and CPI supervisor. The focus on child safety assessments and safety planning is critical to child protection.

3. Legislative changes: Implementation of the Safe Harbor Act

Targeted Activity: Complete and launch a statewide human trafficking screening tool – completed.

Targeted Activity: Complete and launch a level of placement tool – completed.

Targeted Activity: Complete a human trafficking specific assessment tool – ongoing.

In January 2016, DCF launched five statewide clinical work groups to address: the adoption or development of a human trafficking assessment tool; identify what types of clinical intervention are appropriate for CSEC identified youth; create metrics and outcome expectations for safe placements; to develop or adopt a training curriculum for mental health professionals; and assess how to leverage the existing community mental health and substance abuse treatment facilities for treatment of CSEC identified youth. The work group deliverables are due by December 31, 2016.

Targeted Activity: Update the data collection process for the most comprehensive capture of CSEC youth statistics – ongoing.

Florida Safe Families Network (FSFN) modifications ensure data accurately identifies victims of CSEC. The two maltreatments associated with human trafficking: (1) Human Trafficking – Labor and (2) Human Trafficking – CSEC. Within the human trafficking – CSEC maltreatment there are three types of reports: in-home, other, and institutional. Data is also available regarding the type of perpetrator involved with the human trafficking.

January 2016, DCF began a study with RTI, Inc., a recipient of a federal grant, to explore the prevalence of CSEC within the child welfare system. This comprehensive assessment will identify opportunities to better recognize victims and highlight the strengths and challenges of the existing system.

Targeted Activity: Develop and disseminate guidance, policies, and training - completed.

Goal 1, Objective B. The focus of this objective is to increase protective factors in focus families to reduce maltreatment.

The year three update on the protective factors prevention strategy follow:

The Department is a key participant in the legislatively mandated comprehensive approach to the promotion of adoption, support of adoptive families, and prevention of abuse, abandonment, and neglect of children (s. 39.001, F.S.). The Department, regions, circuits and other partners continue to work in concert with the Office of Adoption and Child Protection in the development in the Child Abuse Prevention and Permanency Plan (CAPP) for 2016-2020.

A significant portion of this planning process is an intentional incorporation of the protective factors developed through the research of the Center for the Study of Social Policy. The prevention strategies around protective factors includes statewide and local initiatives, and is heavily collaborative across various state agencies and other partners. For instance, the Department provides technical assistance toward infusing protective factors into local prevention systems; and works with Healthy Families Florida, through the evidence-based home-visiting program, to sustain and increase capacity for serving families at high risk of child maltreatment due to domestic violence, substance abuse, and mental health issues.

During the report period, the Department also issued a solicitation for the development, operation, expansion, and enhancement of community-based, prevention focused programs and activities designed to strengthen and support families, to prevent removal of children from their homes. Seven contracts were awarded to Community-based Care lead agencies. Services will be provided to families whose children have been determined to be safe, but at high or very high risk for future maltreatment based on the Child Protective Investigator's actuarial risk assessment. Case coordination will occur throughout the life of the case and is targeted at building a family's protective factors and addressing barriers to long-term safety.

Local plans also include multiple strategies for increasing protective factors. Families, local social services agencies, faith-based organizations and other community stakeholders. The goals are to develop and implement the five-year primary and secondary prevention strategies for the children and families in local communities

The development of protective factors depends on flexibility and the ability to address state and local needs as part of Florida's diverse and multi-partner approach to child abuse prevention. The framework defined by Florida's statutory requirements for the Child Abuse Prevention and Permanency Plan and the structure of state and circuit/local planning teams provides a robust and collaborative set of interventions that will be monitored and used to adjust the state's response to critical social needs, particularly child safety. No single intervention, whether proven or promising, would be as powerful.

The Department's collaboration and participation in the development and implementation of the Child Abuse Prevention and Permanency (CAPP) Plan is also part of the Department's Child Abuse Prevention Treatment Act (CAPTA) plan. Continuing this process is an essential part of the CAPTA initiative; see also Chapter VIII.

Targeted Activity: Collaborate in the development of revisions to the CAPP for 2016 – 2020, and ensure alignment with the CFSP's goals and objectives including child safety and protective factors. -Ongoing.

The modification to this targeted activity captures the ongoing collaboration with the Office of Adoption and Child Protection under the Executive Office of the Governor regarding prevention activities.

The Department, regions, circuits and CBCs continue to work in concert with the Office of Adoption and Child Protection to identify opportunities to align outcome measures and activities to be included within the state plan.

Targeted Activity: Annually, analyze local and state progress toward prevention and protective factor goals in the CAPP in collaboration with the Office of Adoption and Child Protection, and use this data to inform any adjustments to the CFSP as part of the Annual Progress and Services Review. - Ongoing.

The framework of the original CAPP Plan provided the foundation to develop the next five-year state plan. Coupled with new research from the Centers for Disease Control and Prevention and from the Center on the Developing Child at Harvard University, the state plan recognizes a child's relationship with others inside and outside the family plays a role in healthy brain development, as well as in the development of physical, emotional, social, behavioral, and intellectual capacities.

A core component of the state plan is based on the research conducted by the Center for the Study of Social Policy that found there are protective factors that can make a difference for families. These protective factors reduce the incidence of child abuse and neglect by providing parents with what the parent needs in order to parent effectively, even under stress. Strengthening Families – the intentional incorporation of the protective factors to prevent child maltreatment, continues to be promoted and applied throughout the state. It costs little to incorporate activities that build protective factors into existing state programs and systems to strengthen the protective capacities of parents and caregivers.

Goal 1, Objective C. This objective aims to strengthen the connections between child welfare and other organizations involved in improving protective or risk factors related to child abuse (domestic violence, mental health, substance abuse, education). See Goal 3, page 114, for progress update.

Goal 2

Children have permanency and stability in their living situations and the continuity of family relationships and connections is preserved for children.

Permanency for children remains one of the three most important and challenging areas for child welfare. The preferred permanency option is remaining safely with their own families. Other permanency arrangements include, in descending order of preference (s. 39.621, F.S.):

- Reunification;
- Adoption, if a petition for termination of parental rights has been or will be filed;
- Permanent guardianship of a dependent child;
- Permanent placement with a fit and willing relative; or
- Placement in another planned permanent living arrangement.

Florida Performance Measures of Progress

MEASURES	Observed Performance	Lower Risk Standardized Performance	Risk Standardized Performance	Upper Risk Standardized Performance
Permanency in 12 months (entries) (National Performance – 42.1%)	46.5%	45%	45.8%	46.6%
Permanency in 12 months (12-23 mos) (National Performance – 45.9%)	52.8%	49.3%	50.6%	51.8%
Permanency in 12 months (24+ mos) (National Performance – 31.8%)	43.6%	35.1%	36.4%	37.7%
Placement stability (National Performance - 4.44)	5.32%	5.58%	5.67%	5.77%

Source: Florida CFSR Data Profile Dated May 2017

GOAL 2:

Strategy A. Implement practice initiatives that will improve the permanency and stability of children's living situations.

The timeliness of achieving permanency and stability of a child's living arrangements, whether in a permanent or temporary setting, are also important. An additional area of emphasis in Florida's PIP is further skill development for child welfare professionals, Children's Legal Services (CLS), and the judiciary on permanency planning, modification of goals, and execution.

Achieving permanency in a timely fashion is inextricably linked to factors also linked to safety. A family must be able to keep their child safe in a nurturing environment, and the traumatic experiences that might lead to problematic behaviors must be addressed as expeditiously as possible to ensure reunification or other permanency placements are not disrupted, with an accompanying return to dependency in the child welfare system. Family engagement skills of child welfare professionals are equally important. Child welfare professionals must engage with the parents (mother and father) in a positive manner to ensure full partnership while receiving child welfare services.

Returning children home through reunification is the first preference for permanency. Other permanency goals allow children to be placed with relatives through permanent guardianship with a fit and willing relative. In recent years, Florida has exceeded annual goals for adoption.

Although, the number of licensed foster homes in Florida has increased, there is an inadequate number of homes with capacity for sibling groups and children experiencing significant emotional and behavioral needs. The Department and CBC lead agencies are tailoring recruitment efforts for homes to meet the individual characteristics of children in care. Coupled with this is the need to facilitate improved placement matching.

The key activities focus on practice initiatives to improve the permanency and stability of children's living situations.

1. Increase the availability of quality placement settings for children in out-of-home care, with a focus on homes for sibling groups.
2. Seek technical assistance from National Capacity Building Center for States on diligent recruitment of foster family homes, geo mapping and market segmentation, and implement at least one recommendation for improving recruitment of foster families.
3. Provide workshop for judiciary and court personnel focusing on timely establishment of appropriate permanency goals at Child Protection Summit.
4. Collaborate with the Court Improvement Program on joint Continuous Quality Improvement (CQI).
5. Conduct black belt project to identify root causes of placement instability and identify recommendation(s) for statewide implementation.
6. Implement newly developed statewide operating procedure related to Child Placement Agreements, CFOP 170-11, Chapter 4, requiring child welfare professionals to work together with caregivers for children with identified behavioral management needs. The new operating procedure also focuses on the need to keep siblings together. The process for developing operating procedures involves extensive collaboration – the workgroup for this specific operating procedure included CBC representation, child welfare professional supervisors, legal, foster parents, and other related stakeholders. This practice modification results from a pilot project conducted between 07/2016 through 12/2016 with five CBCs.
7. Strengthen the permanency hearing decision process.
8. Ensure that caregivers receive actual notice and a meaningful opportunity to be heard at all court hearings involving a child in their care.

9. Conduct statewide training on cultural competency in recruitment based on amendment to Chapter 65C-13, F.A.C., Adoptions, which addresses cultural competency and recruitment components.
10. Implement local practice initiatives, such as Rapid Family Engagement, to assist staff with immediate engagement of parents to discuss conditions for return and start case planning process.

Strategy B. Implement practice initiatives that will help ensure the continuity of family relationships and connections is preserved for children.

Statewide there continue to be difficulties with ongoing efforts towards engaging parents, especially fathers. When child welfare professionals are not consistently working together with the parents, this impacts successful reunification, as well as other permanency options. Although this strategy focuses on improving family engagement, the knowledge and skillset of child welfare professionals regarding family engagement directly relates to improving safety and well-being outcomes.

There are four key activities addressing continuity of family relationships and preservation of connections for children.

1. Evaluate implementation of the May 2016 issuance of CFOP 170-9, Family Assessment and Case Planning, to guide family engagement regarding family functioning assessments and case planning throughout the life of the case. The process for developing operating procedures involves extensive collaboration – the workgroup for this specific operating procedure included CBC representation, child welfare professionals and supervisors, legal, and other related stakeholders.
2. Implement improved and/or expanded kinship search processes or procedures so that more children and sibling groups are placed quickly with relatives, as appropriate.
3. Conduct Just In Time training/technical assistance on maintaining a child's connections at quarterly Quality Parenting Initiative (QPI) statewide meeting with foster parents, relatives, non-relatives, child welfare professionals and providers.
4. Expand capacity for Permanency Roundtables including Youth Centered Permanency Roundtable model. Florida has 12 CBCs conducting Permanency Roundtables with plans to train and involve additional sites.

Strategy C. The state's child welfare information system, FSFN, will have accurate and timely data that supports child well-being.

FSFN is the state's official case file and record for each investigation and case, and is the official record for all homes and facilities licensed by the state or approved for adoption placement. All pertinent information about every investigative and case management function must be entered into FSFN within 48 hours/2 days. The FSFN electronic case file is the primary record for each investigation, case and placement provider, including all related financial expenditures and activities.

FSFN supports child welfare practices and the collection of data. Child welfare professionals can readily identify the status, demographic characteristics, and goals for the placement of every child who is (or

within the immediately preceding 12 months, has been) in foster care by accessing the Legal Record page. FSFN fully supports the identification of the status of every child in foster care.

The accuracy of quantitative reports is critical to the on-going assessment of Florida's child welfare system. There are Topic Papers, User Guides, and Desktop Guides to ensure the accurate use of FSFN. The Department strives to ensure data is accurate through on-going review of all items and discussions on conference calls and in quarterly meetings.

The key strategy to monitor compliance of accuracy and timely data entry in FSFN, focusing on placement and living arrangement, addresses the issue of accurate and timely data entry identified during the round three CFSR in 2016.

YEAR THREE UPDATE:

The progress made over the report period specific to the strategies and targeted activities (CFSP 2015-2019, Chapter V) to improve placement stability and permanency for children in out-of-home care is below. The strategies to ensure timely and lasting permanency for children include:

1. Continued implementation of the new child welfare practice model
2. Quality Parenting Initiative (QPI)
3. Local Permanency Initiative
4. Adoption Supports

A summary of the strategies and update follows:

1. Continued implementation of the child welfare practice model

The approach to revising practice throughout all levels of child welfare is also designed to improve permanency for children. By improving family assessment (specifically through the Family Functioning Assessment – Ongoing), more closely aligning assessment with case plans and services, and improving decision-making about reunification as part of case management, the child will not only be safer but families will in many cases be able to become stronger and more nurturing., supporting timely reunification.

Targeted Activity: Continued implementation of the child welfare practice model. – Ongoing
See summary of strategies and year three update on page 99.

2. Quality Parenting Initiative (QPI)

Foster parents and other caregivers are vital partners in working with families on the pathway to permanency. The knowledge, skills, abilities, and emotional commitment to the children in their care contribute to faster, more lasting reunification as well as to their ability to work with case managers during other activities for achieving goals for the child and family.

The QPI design ensures that children are residing in an out-of-home care setting with a caregiver who:

- has the ability to care for the child,
- is willing to accept responsibility for providing care, and

- is willing and able to learn about and be respectful of the child's culture, religion and ethnicity, special physical or psychological needs, any circumstances unique to the child, and family relationships.

In addition, QPI promotes the participation and engagement of foster care parents in the planning, case management, court proceedings, and delivery of services for children who are residing in Florida's out-of-home care system, while working toward the child's long-term permanency and other goals.

Many areas of the state are actively promoting QPI not only for its improvements in caregiver skills, but also as a recruiting and retention tool; if a caregiver is given training, tools, and respect as a partner in reaching goals for the child and family, they are more likely to remain engaged. QPI also includes special topic areas for foster parents and, in some cases youth – particularly around their rights to participate in court processes.

The Department will continue to refine and expand QPI across the state, through ongoing training and tools offered on-site as well as through the information portal of the Center for Child Welfare, particularly the just-in-time training offerings. (http://qpiflorida.cbcs.usf.edu/index.html)

Targeted Activity: Annually: as part of the Annual Progress and Services Report, summarize progress on the state and local actions. - Ongoing.

All but two (2) of Florida's CBCs actively participate in the Quality Parenting Initiative. In addition, the QPI approach to a partnership with foster parents and caregivers includes child protective investigators and case managers, instead of limiting involvement to foster parent recruiting and licensing staff. Refer to Appendix B, Foster and Adoptive Parent Diligent Recruitment Plan.

3. Local Permanency Initiatives

A wide array of strategies related to permanency have been underway for some time across Florida. One of the strongest in relation to timely permanency is the Permanency Roundtables approach, as implemented with technical assistance from Casey Family Programs. In partnership with Casey Family Programs and with the support of the Department of Children and Families, Community-based Care lead agencies (CBCs) continued to utilize Permanency Roundtables.

The Department continues a close partnership with the Casey Family Programs on the Permanency Roundtable Project. Each new site begins with their PRT process with a review and assessment of all youth with an APPLA goal. The lead staff persons for the PRT sites meet quarterly to discuss successes and barriers to permanency. This provides an opportunity for the leads to share what is working and where they need process improvements. The collaboration with the Casey Family Programs will continue with a plan going forward to train and involve at least one new CBC per year through 2019.

Other local initiatives include Family Connections, family team conferencing, dedicated post-adoption supports, Family Engagement model programs, and many others.

Targeted Activity: Annually, report and summarize status of local initiatives for the Annual Progress and Services Report cycle. Ongoing.

There are 12 CBCs conducting Permanency Roundtables (PRT). Regional and CBC specific initiatives are described in Chapters I and II.

4. Adoption Supports

Adoption has been a successful outcome for thousands of children in Florida. In order to maintain this success, the Department is focusing activities in support of adoption as a permanency outcome to include recruitment of adoptive parents (see Appendix B) and provision of post-adoption supports.

Post-adoption supports: As described in Chapter II under Adoption Services, the Department continues to place emphasis on the provision of post-adoption supports to families in order to sustain successes for forever families. Services include support groups, adoption competency specialists and training, and post-adoption services counselors.

Targeted Activity: Annually, analyze local and state progress toward adoption and other permanency goals and use this data to inform any adjustments to the CFSP as part of the Annual Progress and Services Review. - Ongoing.

The findings from the round three CFSR informed the adjustments to the CFSP. Department and Regions work closely in the analysis of data and progress.

CFSP 2015-2019, Chapter V, Goal 2, Objective B also addresses timely permanency - the state's case review system will support timely permanency with appropriate participation and planning. This activity is captured in Florida's PIP under Goal 2, Strategy A, Key Activities 3, 4, and 7.

Collaboration with the Court System and Children's Legal Services

The legal aspects of child welfare, particularly with respect to permanency, are an important component to achieving success. The Office of Child Welfare has a long-standing collaboration with the Office of Court Improvement within the court system, and regions develop intense working relationships with local courts. Perhaps the most visible result of this collaboration is the Dependency Summit, jointly planned and attended by child welfare specialists, community-based agencies, foster parents, youth, attorneys, judges, and many other partners. Each year, Florida's Court Improvement Program (CIP)—which works within the Office of Court Improvement—and the statewide Dependency Court Improvement Panel work very closely with the Department to ensure that judicially relevant content is offered at the Child Protection Summit.

Statewide, a major CIP project was implementation of evidence-based parenting (EBP) programs. Nine circuits worked on this initiative from 2013 to 2016 and received targeted technical assistance. Another circuit (Circuit 11) had already implemented evidence-based parenting programs, but still participated as a pilot/mentor site to both monitor ongoing fidelity, as well as to assist and coach the other participating sites.

Enabling parenting providers to offer evidence-based programs was only part of the project; another key component involved Dr. Lynne Katz (director of the University of Miami, Linda Ray Intervention Center), helping providers develop effective ways to convey information on parental progress to the judges and magistrates in the courtroom. The primary court-related activities that Dr. Katz worked on with providers were behavioral observations of parent-child dyads, and templates for reporting ongoing progress to the

court. Dr. Katz also worked with providers to ensure that parent-child interactive components were implemented and that site logistics were appropriate to accommodate these interactive activities. Judges and magistrates having pertinent information in court on parents' quantifiable progress in a program—as opposed to simply observing that a parent has received his or her certificate of completion for a course—is a crucial feature of this initiative. Clear, reliable information that is reported consistently will help judges make better-informed decisions in the cases they hear. By August 2016, the nine sites had all completed the parenting provider trainings as well as the behavioral observation trainings, and CIP ended its contractual relationship with the lead consultant Dr. Katz. The nine sites plan to continue providing EBP parenting programs, and the CIP shifted all of its resources to Early Childhood Court implementation.

Targeted Activity: Annually, convene the Dependency Summit. Ongoing.

The 2016 Dependency Summit in Orlando occurred between 9/7 and 9/9/2016 (link to the 2016 Child Protection Summit Summary Report is below); the 2017 Dependency Summit is scheduled to occur the end of August 2017 in Orlando.
http://www.centerforchildwelfare.org/Training/2016cpsummit/2016ChildProtectionSummitSummaryReport.pdf

Targeted Activity: Monthly, continue Monthly OCI/OCW/CLS/GAL/DOE meetings. - Ongoing

The Office of Court Improvement (OCI) and the Department of Children and Families are among several child welfare partners who participate in monthly multiagency collaboration meetings. These meetings provide an excellent forum for information sharing as to various agency initiatives, in addition to the opportunities for collaboration among the various initiatives.

Targeted Activity: Annually, report and summarize status of local initiatives for the Annual Progress and Services Report cycle. - Ongoing.

The Evidence–based Parenting (EBP) Initiative facilitated monthly technical assistance calls between the participating circuits and Dr. Lynne Katz, parenting and child development specialist from the University of Miami. The initiative focused on universal requirements for evidence-based parenting classes, pre and post-test measures, parent readiness and parent-child observations with children 5 and under. Through this ongoing process judges, judicial staff, and community stakeholders have been able to define and understand the process for a parenting program to become evidence-based as well as understanding the process for accessing programs meeting research-based criteria. While the CIP maintains the lead in this model courts initiative, each local jurisdiction participating in the initiative includes the partnership of the Department and Community-based Care agencies. The specific waiver activities are determined on a local level and implemented with full partner collaboration.

The Department of Children and Families has continued to collaborate with the CIP to support the Early Childhood Court initiative, a Florida Court Improvement lead project. Early Childhood Court addresses child welfare cases involving children under the age of three. It is a problem-solving court – where legal, societal, and individual problems intersect. Problem-solving courts seek to address not only the legal issues but also the underlying non-legal issues that will benefit the parties and society as well. This specialized court docket provides greater judicial oversight through more frequent judicial reviews and a multidisciplinary team approach. The team works in a non-adversarial manner to link the parties to treatment and services. Chapter II includes information on local efforts to expand the Early Childhood Court initiative. There continued to be substantial momentum to expand Early Childhood Court

throughout the state. Understanding of both the vulnerability and the opportunity for changing the developmental trajectory for maltreated children has inspired dependency judges and local coalitions in 17 sites to begin Early Childhood Court. Most counties are in the exploration and installation stages of implementation, and several are in the initial implementation stage; all are eager to expand best practices and deeply committed to improving outcomes for young children in dependency courts. The Department is a full partner in this initiative on a statewide level and local community level. Other collaborative partners include the Community-based Care agencies, Florida State University, Children's Legal Services, mental health providers, infant mental health specialists, foster parents, and other community partners. Activities are underway to continue to provide support for the project across sites, along with planning for long-term sustainability.

Goal 3

Families have enhanced capacity to provide for their children's needs, and the well-being of children is improved through services to meet their education, physical health and mental health needs.

Well-being, defined in terms of family capacity, educational success, physical health, and behavioral health, is perhaps the outcome that receives the least focus but is equally important to the lives of the children and families involved in the child welfare system.

Florida shows strength with accurately assessing children's educational, physical, dental and mental/behavioral health although further efforts are necessary to ensure the provision of services meets the identified needs of the children. The round three final CFSR report identified meeting children's educational needs as an area where Florida has shown significant improvement.

GOAL 3 STRATEGIES:

Strategy A. Implement practice initiatives that will improve families' capacity to provide for their children's needs through quality family assessments, family engagement and appropriate supports to address identified needs.

The child welfare practice model focuses on safety and emphasizes quality assessments and engagement of children and their parents. By improving family assessment, more closely aligning assessment with case planning and improving decision-making about the needs of children and their families, the child welfare professional helps the child to be safer and families to become stronger and more capable of maintaining and enhancing their well-being. Once service needs are identified, the child welfare professional's efforts should be concentrated on timely referrals, encouraging participation in services and assisting with the receipt of services, identifying barriers to service provision and appropriate follow-up after implementation of services. The ongoing assessment of service availability within each community will lead to an enhanced array of services to meet the identified needs of children and families.

Insufficient family engagement, particularly around case planning and achievement of case plan goals, negatively impacted timely permanency. The case plan is to be developed and updated jointly with the child's parents, the child (if age appropriate), the case manager and supervisor, and the Guardian ad Litem (GAL). Principles of Family Team Conferencing or other family-inclusive planning models are to be used in the case planning process. Improving the child welfare professional's engagement skills is anticipated to enhance and support quality family assessments and collaborative case planning throughout the life of the case.
Child welfare professionals must regularly meet with the mother and father of children in out-of-home care with the same sense of priority as seeing the child. Increased visitation with parents (mother and father), including those who are incarcerated, is essential. Additional focus on the quality of contacts with children, particularly in face-to-face, private contacts every month which include case plan discussion in an age appropriate manner is also addressed.

The six key activities focus on ensuring child welfare professionals make concerted efforts to continually assess needs of children, parents, and caregivers to identify services necessary to achieve case plan goals, adequately address the issues relevant to the agency's involvement with the family, and provide services.

1. Improve availability and access to the child welfare service array within each community.

2. Publish a statewide life skills progress guide for child welfare professionals, focusing on assessing independent living skills, social, self-esteem, and coping skills.
3. Ensure children placed with relatives receive Relative Caregiver Program benefits (Priority of Effort), as appropriate.
4. Modify and implement CFOP 170-10, Providing Services and Support for Children in Care and for Caregivers, to providing support for relative caregivers.
5. Develop and implement best practice tool for child welfare professional's quality visits with children and their mothers and fathers based on workgroup research and recommendations. Although children are visited at least once every 30 days, the visits are not of consistent quality. This key activity relates to quality of visits.
6. Obtain technical assistance, as appropriate at the local level, from national experts in the state's child welfare practice model to facilitate improvement in assessments, family engagement, safety planning, supervisory consultation, and case planning.

Strategy B. Implement practice initiatives to assure that children receive appropriate services to meet their educational needs.

Through the statewide efforts for normalcy, there is emphasis on parents, foster parents, and caregivers becoming more engaged in the child's education. Child welfare professionals must improve the consistency in making concerted efforts to assess the educational needs of the children in out-of-home care and addressing these needs in case planning. Florida does a better job at assessing needs than ensuring that services to meet the specific need are engaged. The key activities to address educational needs of the child follow:

1. Establish a memorandum of understanding (MOU) between the Department of Children and Families and the Department of Education specific to educational needs of children in out of home care.
2. Update local working agreements between local school districts and CBCs.
3. Assess practice using the Florida CQI and PIP monitored case reviews.
4. Provide quarterly feedback to management (Department leadership, CBC leadership, OCW specialists, child welfare professionals) on findings to inform practice changes or training as needed.

Strategy C. Implement practice initiatives to assure children receive adequate services to meet their physical health, dental health, and mental health needs.

The findings from the Florida CQI Reviews show that providing services to address a child's physical health and mental/behavioral health needs continues to be a challenge. Addressing the mental and behavioral health of children requires engaging families, working toward educational success, and ensuring physical and behavioral health activities are a priority. Case managers must constantly identify needs and provide services to meet those needs, assess whether goals are achieved or conditions improved, and revise approaches to meet changing needs.

The key activity focusing on ensuring children receive appropriate services to meet their physical and mental health needs involves an initiative to integrate child welfare and substance abuse and mental health service systems for child welfare families to enhance families' access to services and ensure appropriate assessment to inform services.

Each region and community has some unique characteristics and some common needs related to the abilities of its families to become strong and nurturing. Certain general approaches, such as the evidence-based home visiting underpinning Healthy Families Florida and the Quality Parenting Initiative discussed previously, are in wide use.

YEAR THREE UPDATE:

The PIP goals, strategies, and key activities incorporate relevant strategies and targeted activities included in CFSP 2015-2019, Chapter V, to improve the array of services. Refer to CFSP 2015-2019, Chapter V., Goal 1, Objective C. The strategy and targeted activities within Objective C align with Florida's PIP, Goal 3. A summary and year three update is below:

1. Integration of Services for Child Welfare and Behavioral Health
2. Domestic Violence and Child Welfare Collaboration
3. Substance Abuse and Mental Health Services Collaboration – Refer to 1. Integration of Services for Child Welfare and Behavioral Health above.

1. <u>Integration of Services for Child Welfare and Behavioral Health</u>

The Department recognizes the necessity for a close relationship between the behavioral health and the child welfare systems and continues to work on methods for supporting collaboration and coordination. The behavioral problems of parents, particularly as they relate to substance use disorders, are readily identified as one of the primary factors contributing to family involvement with child protection agencies and dependency systems. Children in these families are more vulnerable to instances of maltreatment, as diminished parental capacities contribute to child safety concerns. To successfully support families with mental health and substance use disorders the system must realign the current service provision model and move from a philosophy of "task-based case plan compliance" to an effective model of integrated treatment that supports behavioral change and improves parental capacity to safely care for their children. Failure to do so will continue to place children at risk of maltreatment and increased recidivism.

Several significant, long-term initiatives will affect the overall ability of the child welfare program to achieve the broad goal of increasing safety for children. These include:

- Providing training in the area of trauma-informed care for staff and caregivers, specifically as part of the pre-service curriculum and on-line training developed by the Florida Certification Board and in alignment with the child welfare Practice Model.
- Care coordination/case management program inclusion of behavioral health and trauma-informed care under the Child Welfare Specialty Plan as part of the Medicaid Managed Care contract, a key part of the Health Care Oversight and Coordination Plan, and local coordination of child welfare agencies with services provided by the Behavioral Health Managing Entities.
- Florida Children's Mental Health System of Care Expansion Grant and Integration with Child Welfare.

- Project LAUNCH (Linking Actions to Unmet Needs in Children's Health), a five-year grant from the Substance Abuse and Mental Health Administration (SAMHSA). This grant is grounded in the public health approach and works towards coordinated programs that take a comprehensive view of health by addressing the physical, emotional, social, cognitive and behavioral aspects of well-being.
- Children's Mental Health Wrap Around (100806). The goal of these funds is to promote social and emotional well-being and resilience among children with a mental, behavioral or emotional disorder or other condition that may require clinical attention who have been removed or are at risk of removal due to abuse or neglect.
- Community Action Teams (CAT) provide an alternative to out of home care to children with serious behavioral health disorders. The CAT model is a team based integrated service delivery approach.
- Family Intensive Treatment Teams (FIT) are a legislatively funded pilot project for the provision of family-focused, team-based services for parents in the child welfare system with substance use disorders. The teams integrate services and treatment by providing treatment for substance use disorders, treatment for co-occurring disorders, providing parenting interventions, and through therapeutic coordination for all family members.
- Child Welfare Project Team formed with the charge to develop recommendations for improved identification of need, access to evidence-based services, coordination of care using a family-based focus, and identification of resources necessary to implement desired changes. The team was comprised of participants from the Department's Office of Child Welfare and the Substance Abuse and Mental Health office, Community-based Care lead agencies, Managing Entities, FADAA, and behavioral health providers.

  Focused on system change to support a philosophical shift to concentrate on the implementation of a treatment-based service model designed to addresses behavioral health problems while improving family functioning and strengthening child welfare related outcomes. Components of this approach are based on prior research and effectively build on the practice framework:

  - Assessment - Use a comprehensive and continuous approach to assessing safety issues, risk factors and evaluating family functioning.
  - Cross System Competencies - Strengthen cross-system understanding and professional/provider competencies and practices as they relate to treatment goals, service planning, practice models, outcome expectations and legal requirements.
  - Treatment Modalities - Strategically select and integrate dedicated service modalities addressing the specific needs of the family.
  - Leadership - Create a systematic and focused leadership approach to implement the framework.

Targeted Activity: By June 30, 2015, develop five on-line courses relating to behavioral health for child welfare will be in use. Completed.

Targeted Activity: Child welfare program staff will participate on the state level Children's Mental Health System of Care (CMHSOC) Expansion Implementation Core Advisory Team and on the region system of care teams, to provide child welfare input for implementation of the SOC grant. - Completed.

2. Domestic Violence and Child Welfare Collaboration

Family violence is an area that child welfare professionals must understand and be prepared to deal with. Family violence is one of the three most critical factors (along with substance abuse and mental health) that brings families to the attention of the Florida child welfare system. The Child Welfare Practice Model also includes special content and tools in relation to Domestic Violence.

Targeted Activity: Quarterly meetings with the FCADV, child welfare, and other partners - Completed.

The Florida Coalition Against Domestic Violence, the Department's Domestic Violence Program Office, and the Office of Child Welfare hold quarterly meetings. These meetings serve as collaboration and integration opportunities in support of ongoing initiatives.

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Attachment A

Florida's Annual Progress and Services Report
June 30, 2017

Plan for Improvement: Summary Matrix

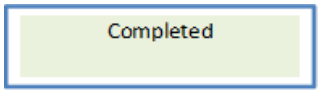
FLORIDA'S CHILD WELFARE SYSTEM FIVE YEARS FROM NOW

OUR VISION….Every child in Florida thrives in a safe, stable, and permanent home, sustained by nurturing relationships and strong community connections.

GOAL 1: Children involved in child welfare will have increased safety and expanded protection		
Measures of progress shifted to Florida's Program Improvement Plan – Measurement Plan; federal Child and Family Services Review outcomes and items. CFSR 3 Data Profile (May 2017) Recurrence of Maltreatment – national performance 9.5% Maltreatment in Foster Care – national performance 9.68% Effective July 2015, Florida utilizes the federal Online Monitoring System (OMS) for QA/CQI reviews. Safety 1: Children are, first and foremost, protected from abuse and neglect.	Actuals: CFSR VI. 10.7% (FY14-15) CFSR VI. 12.61 (FY2015ab)	Targets (to be achieved by end of year five): CFSR VI. 9.5% (national performance) CFSR VII. 9.68 (national standard) Florida has not met the national standards for recurrence of maltreatment and maltreatment in foster care

GOAL 1: Children involved in child welfare will have increased safety and expanded protection		
Objectives	**Interventions**	**Benchmarks**
	1. Practice Model (formerly known as Safety Methodology)	• December, 2017: Initial Implementation Statewide Year Two: 99% of child protective investigations initiated through September 2015 utilized the Child Welfare (Safety) Practice Model **Year Three:** 100% of child protective investigations utilize the Child Welfare Practice Model. As of 3/2017, 65.8% of CBCs utilize the ongoing family functioning assessment (Child Welfare Practice Model). • December, 2018: Full Operation
	2. Rapid Safety Feedback Completed	• Annual CQI Plan incorporating Rapid Safety Feedback Process: Year one and thereafter Year One: Completed. Refer to Appendix A, Continuous Quality Improvement Plan. • Quarterly Summaries by Region: **Year Three:** Completed. Refer to Monthly Key Indicator Reports http://centerforchildwelfare.fmhi.usf.edu/QualityAssurance/ChildWelfareKeyIndicators.shtml
	3. Legislative changes: Safe Harbor Act Completed	TBD: Develop implementation plan (dates and action steps) for Safe Harbor Act implementation; including – By September,2014, participate in the first meeting of the Statewide Council on Human Trafficking (Secretary or Designee is co-chair; s. 16.617, F.S.) Year Two: Completed

GOAL 1: Children involved in child welfare will have increased safety and expanded protection		
Objectives	**Interventions**	**Benchmarks**
Objective B. Increase protective factors in focus families (in home, out-of-home, at risk) to reduce maltreatment.	1. Protective Factors Prevention Strategy	• By June 30, 2015: Collaborate in the development of revisions to the CAPP for 2016 – 2020, and ensure alignment with the CFSP's goals and objectives including child safety and protective factors. **Year Three:** Ongoing. The Office of Adoption and Child continued to work with state agencies as well as stakeholders to identify opportunities to align outcome measures and activities. • Annually: Analyze local and state progress toward prevention and protective factor goals in the CAPP in collaboration with the Office of Adoption and Child Protection, and use this data to inform any adjustments to the CFSP as part of the Annual Progress and Services Review. **Year Three:** Ongoing. The framework of the original CAPP plan provided the foundation to develop the next five-year plan coupled with research from the Centers for Disease Control and Prevention.

GOAL 1: Children involved in child welfare will have increased safety and expanded protection		
Objectives	**Interventions**	**Benchmarks**
Objective C. Strengthen the connections between child welfare and other organizations involved in improving protective or risk factors related to child abuse (domestic violence, mental health, substance abuse, education) [systemic factor - agency responsiveness to the community]	1. Integration of Services for Child Welfare and Behavioral Health 	• By June 30, 2015: o Five on-line courses relating to behavioral health for child welfare will be in use. Year One: Completed. o Child welfare program staff will participate on the state level CMHSOC Expansion Implementation Core Advisory Team and on the region SOC teams, to provide child welfare input for implementation of the SOC grant. Year One: Completed. o QA/CQI results and feedback: annually in October Year One: Completed.
	2. Domestic violence and Child Welfare Collaboration 	• Quarterly meetings with the FCADV, child welfare, and other partners **Year Three:** Completed.
Objective D. Staff and provider training will support skill development in areas of emphasis, particularly identification of safety and risk. [systemic factor]	1. Training Plan 	Deploy new pre-service training curriculum by beginning of SFY 15/16 (July 2015) Year One: Completed. Deployed in January 2015.
	1. Practice Model (formerly known as Safety Methodology).	See Objective A

GOAL 1: Children involved in child welfare will have increased safety and expanded protection		
Objectives	**Interventions**	**Benchmarks**
and timely data that supports child safety. [systemic factor]	2. FSFN training and CQI Completed	• Deploy new pre-service training curriculum by beginning of SFY 2015/16 (July 2015) Year One: Completed. Deployed in January 2015 • Develop data integrity approach during SFY 2015/16 Year One: Completed. Deployed in January 2015 • Analyze QA/CQI results and feedback **Year Three:** Completed. See the monthly Key Indicators Report and final CFSR report for round 3. http://centerforchildwelfare.fmhi.usf.edu/QualityAssurance/ChildWelfareKeyIndicators.shtml http://centerforchildwelfare.fmhi.usf.edu/qa/CFSRTools/2016%20CFSR%20Final%20Report.pdf

GOAL 2: Children involved in child welfare will live with permanent and stable families, avoiding entry into foster care and disruption and return to out of home placement.		
Measures of Progress: Measures of progress shifted to Florida's Program Improvement Plan – Measurement Plan; federal Child and Family Services Review outcomes and items. Permanency in 12 months (entries): National Performance – 42.1% Permanency in 12 months (12-23 mos): National Performance – 45.9% Permanency in 12 months (24+ mos): National Performance – 31.8% Re-entry to care in 12 months: National Performance – 8.4% Placement Stability: National Performance- 4.44	**Actuals:** 45.8% 50.6% 36.4% 7.1% 5.67	**Targets** (to be achieved by end of year five): Sustain Sustain Sustain Sustain Informed PIP Activities for Goal 1 (Permanency)

GOAL 2: Children involved in child welfare will live with permanent and stable families, avoiding entry into foster care and disruption and return to out of home placement.		
	1. Practice Model (formerly known as Safety Methodology)	• December, 2017: Initial Implementation Statewide **Year Three:** 100% of child protective investigations utilize the Practice Model**.** 65.8% of cases with approved Family Functioning Assessment – ongoing as of March 15, 2017 • December, 2018: Full Operation • See Goal 1, Objective A: Annual CQI Plan incorporating Rapid Safety Feedback Process: Year one and thereafter
	2. Quality Parenting Initiative	Annually: as part of the Annual Progress and Services Report, summarize progress on the state and local actions. **Year Three:** Completed for report period. Refer to Appendix B, Foster Parent Diligent Recruitment Plan
	3. Local Permanency Initiatives	Annually: report and summarize status of local initiatives for the Annual Progress and Services Report cycle. **Year Three:** Completed for report period. Refer to Chapter II

GOAL 2: Children involved in child welfare will live with permanent and stable families, avoiding entry into foster care and disruption and return to out of home placement.		
Objective A. (cont.)	4. Adoption Supports	• Collaborate on the development of revisions to the CAPP for 2016 – 2020, and ensure alignment with the CFSP's goals and objectives including adoption and permanency goals **Year Three:** Ongoing**.** The Office of Adoption and Child Protection gained input from members of the CAPP advisory council and local taskforces and built upon previous outcome measures to establish statewide goals. • Annually: Analyze local and state progress toward adoption and other permanency goals in the CAPP in collaboration with the Office of Adoption and Child Protection, and use this data to inform any adjustments to the CFSP as part of the Annual Progress and Services Review. **Year Three:** Ongoing. The Office of Adoption and Child Protection continued to work with state agencies and partners to identify opportunities to align outcome measures and activities.

GOAL 2: Children involved in child welfare will live with permanent and stable families, avoiding entry into foster care and disruption and return to out of home placement.		
Objective B. The state's case review system will support timely permanency with appropriate participation and planning. [systemic factor]	1. Collaboration with the Court System and Children's Legal Services	• Annually: Convene the Dependency Summit **Year Three:** Completed for this report period. Planning underway for the 2017 Summit, 8/29 – 31, 2017. • Monthly: Continue Monthly OCI/OCW/CLS/ GAL/DOE meetings **Year Three:** Completed for this report period. • Annually: report and summarize status of local initiatives for the Annual Progress and Services Report cycle **Year Three:** Completed for this report period. • Annually: Review CQI Plan and analyze results & feedback for improvements **Year Three:** Refer to CQI Plan update in Appendix A
Objective C. Staff and provider training will support skill development in practice areas of emphasis.	1. Implement the Practice Model and the Training plan. Completed	Inclusion of timely establishment of permanency goals in pre-service training curriculum in year one. Deploy new pre-service training curriculum by beginning of SFY 2015/16 (July 2015).

GOAL 2: Children involved in child welfare will live with permanent and stable families, avoiding entry into foster care and disruption and return to out of home placement.		
Objective D. Foster and adoptive parent licensing, recruitment, and retention will support permanency	1. Implement the Foster and Adoptive Parent Diligent Recruitment Plan	Annually: report and summarize status of state and local initiatives for the Annual Progress and Services Report cycle. **Year Three:** Completed for report period. Refer to Appendix B, Foster Parent Diligent Recruitment Plan
Objective E. Service array will emphasize proven, effective approaches to avoiding disruption.	1. Expand quality and availability of supports through the Title IV-E Foster Care Demonstration Waiver	Annually: as part of the Annual Progress and Services Report, summarize progress on the recommendations of the Florida Services Gap Analysis Report **Year Three:** In progress. Florida continues to assess the service array. The Department is working with the CBCs to establish baselines in all service categories.

GOAL 3: Children involved in child welfare will have improved well-being (education, physical health, and behavioral health) and live with nurturing families.		
Measures of Progress: CFSR: Well-Being 1, Item 12 CFSR: Well-Being 1, Item 15 CFSR: Well-Being 2, Item 16 CFSR: Well-Being 3, Item 17 CFSR: Well-Being 3, Item 18	**Actuals:** Baseline will be set following Round 3 CFSR set for 2016	**Targets (to be achieved by end of year five):** WB 1: Item 12. 58.4% Item 13. 70.7% Item 14. 78.9% Item 15. 51.1% WB2: Item 16. >92% WB3: Item 17. >85% Item 18. >72% **Year 3**: Items 12, 13, 14, and 15 modified to reflect PIP Measurement Plan goals. Regarding items 16, 17, and 18, the related key activities to improve practice must be completed.

GOAL 3: Children involved in child welfare will have improved well-being (education, physical health, and behavioral health) and live with nurturing families.		
Objectives	**Interventions**	**Benchmarks**
	1. Child Welfare Practice Model -	• December, 2016: Initial Implementation Statewide Year Three: 100% of child protective investigations utilize the Practice Model. 65.8% of cases with approved Family Functioning Assessment – ongoing as of March 15, 2017 • December, 2018: Full Operation
	2. Local well-being initiatives	Annually: report and summarize status of local initiatives for the Annual Progress and Services Report cycle. Year Three: Completed for the report period. Refer to Chapter II
	3. Expanded service array through the Title IV-E Foster Care Demonstration Waiver	Annually: as part of the Annual Progress and Services Report, summarize progress on the recommendations of the Florida Services Gap Analysis Report. Year Three: Refer to Chapter IV update to Objective E and Chapter VII.
Objective B. Ensure physical and behavioral health for children through quality assessments and appropriate trauma-informed supports to address needs	1. Implement Health Plan.	Annually: as part of the Annual Progress and Services Report, summarize progress with respect to the Health Plan, including status of the Child Welfare Specialty Plan and psychotropic medication monitoring Year Three: Completed for report period. See Appendix C, Health Care Oversight and Coordination Plan

GOAL 3: Children involved in child welfare will have improved well-being (education, physical health, and behavioral health) and live with nurturing families.		
Objectives	**Interventions**	**Benchmarks**
Objective C. Ensure educational success for children through collaboration with parents, caregivers, local school systems, and other educational agencies. [systemic factor]	1. Education Information and Service Integration for Child Well-being	Annually: as part of the Annual Progress and Services Report, summarize progress on the state and local actions. Year Three: Completed for report period. Refer to Chapter II.
Objective D. Continuous quality improvement will demonstrate child welfare system ability to improve, implement, and sustain quality of services and achievement of outcomes. [systemic factor]	1. Implement CQI/QA plan	Annually: Develop and implement state and local CQI plans. Year Three: Completed. This is a CBC contractual requirement. See Appendix A, Continuous Quality Improvement Plan.
Objective E. The state's child welfare information system, FSFN, will have accurate and timely data that supports child wellbeing. [systemic factor]	1. Implement CQI/QA plan. Completed	• During SFY 2015/16, develop data integrity approach.

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CHAPTER V. Consultation and Coordination with Tribes

Requirements for compliance with the mandates of the Indian Child Welfare Act (ICWA) are contained in Florida Statutes, Florida Administrative Code, and in operating procedure. Child Protective Investigators are required to determine potential eligibility for the protections of the Indian Child Welfare Act at the onset of each child protective investigation. Florida Administrative Code requirements and supporting guidance ensure that children eligible for the protections of the Act are identified at the earliest possible point in the initiation of services. Additionally, the two federally recognized tribes in Florida are familiar with the Child and Family Services Plan (CFSP) and the Annual Progress and Services Report (APSR) and the accessibility of the documents on Florida's Center for Child Welfare website.

The number of ICWA children in ICWA compliant placements decreased slightly from 41 in 2015 to 32 in 2016. Additional out-of-home care data for the reporting period includes:

- The number of children in out-of-home care with race of American Indian/Alaskan Native (regardless of other races): 111
  - Of the 111 children referenced above, the number who have at least one tribal affiliation is: 111
  - Of the 111 children referenced above, the number who have at least two tribal affiliations: 5
- The number of children in out-of-home care identified as ICWA eligible: 47
  - Of the 47 children referenced above, number who are placed in an ICWA compliant placement: 32

The Department seeks tribal representation to assist with training development and other discussions (see Appendix E, the Training Plan). The Department's core pre-service curriculum includes the mandates of the Indian Child Welfare Act. The core pre-service curriculum will be updated to address the provisions from the ICWA final rule published in the Federal Register on June 14, 2016. The Department will continue to involve the tribes in training activities, as described in Appendix E.

The case planning services of the Seminole Tribe of Florida (STOF) Family Services Department handles credit reports for tribal children. The Miccosukee Tribe provides case planning services to its own children; the Department has not received specific information as to whether that includes credit reports. The Department requires the lead agencies to obtain a credit report for youth in care ages 14 to 17. This requirement is applicable to all youth in this age group.

Florida continues to work in collaboration with the state's two federally recognized tribes, the Seminole Tribe of Florida and the Miccosukee Tribe of Indians of Florida, by maintaining and encouraging ongoing contact, support, staff interaction, and opportunities for the tribes to participate in statewide initiatives and training. A third tribe, the Poarch Band of Creek Indians (a federally recognized tribe from Alabama with a reservation located close to the Florida - Alabama border), also is included in the Department's outreach efforts. While the Miccosukee Tribe and the Poarch Band of Creek Indians currently do not participate in Florida events and activities, the Department continues outreach efforts that are respectful of the tribes' cultures and preferences.

The Department is responsible for child protective investigations for the tribes. Each area of the state has staff serving as ICWA liaisons. The Department's operating procedure, CFOP 175-36, Reports and Services Involving American Indian Children, describes processes to be used by child protective investigators and

case managers. The CFOP is located at
http://www.dcf.state.fl.us/admin/publications/policies.asp?path=175 Family Safety (CFOP 175-36).

The Department maintains ongoing collaboration, both statewide and locally, with Florida's recognized tribes. The Department's point of contact, Jessica Johnson, along with Special Projects Administrator of the Seminole Court, Kristi Hill, convenes regularly scheduled conference calls every two months to discuss issues, such as upcoming trainings, training needs, data needs, and review of complex cases from a statewide perspective. There is broad participation during the bi-monthly conference calls to include DCF regional staff, Florida Court Improvement Team, DCF General Counsel, DCF Children's Legal Services, and Tribe Liaisons. Further, all three tribes participate in the annual statewide Dependency Summit and on a statewide dependency court work group.

The Memorandum of Agreement (MOA) to establish protocol for the investigation of allegations of abuse, neglect or abandonment of Native American children who reside on the Seminole Tribe of Florida (STOF) reservation or outside the boundaries of the STOF reservation, but within the state of Florida, has undergone revision during the reporting period.

Pending the signing of the MOA, the Department provides, at the STOF's request, child abuse and neglect investigations and certain case management functions on the STOF reservations. The STOF is developing a tribal court system and regulations for handling child welfare cases in the tribal court system. In the interim, Florida's circuit courts hear dependency court cases resulting from investigations conducted by the Department or its contracted agencies on Seminole reservations.

The tribal representatives for the state's two federally recognized tribes are:

Miccosukee Tribe of Indians of Florida

Dr. John De Gaglia, Director, Social Services Program
Post Office Box 440021
Miami, Florida 33144
Telephone: (305) 223-8380 extension 2267 FAX: (305) 223-1011

Seminole Tribe of Florida

Designated Tribal Agent for ICWA
Attention: Shamika Beasley, Tribal Family & Child Advocacy Compliance & Quality Assurance Manager
Center for Behavioral Health
3006 Josie Billie Avenue
Hollywood, Florida 33024
Telephone: (954) 965-1314 ext. 10372 FAX: (954) 965-1304

Additionally, the representative from the Alabama tribe:

Poarch Band of Creek Indians

Martha Gookin, Department of Family Services
5811 Jack Springs Road
Atmore, Alabama 36502
Telephone: (251)368-9136 extension 2602 FAX: (251) 368-0828

Future Plans

- Provide co-trainings in collaboration with the STOF to child welfare professionals, the courts, and communities across the state. The trainings on the new ICWA regulations will also be offered to the Miccosukee Tribe of Florida.
- Continue working with the Seminole Tribe to complete and execute a Memorandum of Agreement Between the Department and the Seminole Tribe of Florida. In addition, the Southeast Region staff is collaborating with the Seminole Tribe to formalize a local working agreement. The largest Seminole Tribe reservation is located in the Southeast Region.
- Continue regularly scheduled conference calls between the Tribe, the Department, and contracted providers to enhance collaboration and information sharing.
- Continue efforts to engage the Miccosukee Tribe over the next year.
- Establish a protocol with the Seminole Tribe where ICWA cases from the Southeast Region will be heard on the local Seminole reservation site.

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CHAPTER VI. Caseworker Visits

The Department has made it a priority that all children in out-of-home and in-home care are seen by their case manager at least once every 30 days. Florida Administrative Code establishes requirements and standards for content and quality of visits; minimum visitation of every 30 days as opposed to monthly; and types of visits including unannounced visits.

Florida uses the caseworker visit grant funds to support monthly caseworker visits with children who are in out-of-home care. Although the funding is blended in with other child welfare funds, these funds help to enhance the quality and frequency of the visits with children. The minimum standard for caseworker contacts with children in the Florida Administrative Code requires a face-to-face contact with the child occur no less than once every 30 days. Face-to-face contact with the child is required once every seven days for a period of time when a child is initially placed in licensed care or with a relative or nonrelative. Frequency of child contacts is based on many factors such as level of risk, presenting issues in the case, or current circumstances in the child's life. These funds provide the opportunity to contact a child more often in a setting that is most favorable for the child and for the caseworker visits to be well planned and to focus on pertinent issues related to case planning and service delivery.

The data for Florida Caseworker visits for FFY 2016 is below. As reported in December 2016, Florida continues to exceed the 90% federal target for monthly visitation. The data on caseworker visits was obtained using the federal methodology.

The percentage of visits made on a monthly basis by caseworkers to children in foster care: 97%.

The percentage of visits that occurred in the residence of the child: 98%.

Update/Accomplishments

- Published the initial findings for year 1 from the Department funded "Florida Study of Professionals for Safe Families." This project with the FSU Institute on Child Welfare is a five-year, longitudinal study that focuses on worker orientation, supervision, and mentoring for those transitioning from the pre-service training to investigations and case management positions. Through nine months of baseline data collection, completed data were received from 994 study participants. This reflects participation by 85% of all trainees in Florida. About 58% (n = 242) of study participants are case manager and 42% (n = 175) are CPIs. Of those who identify as CPIs (n = 417), 84% are employed by the Department of Children and Families, and 16% are with sheriff's offices. This data will contribute to the baseline, with future findings contrasted to determine whether employment associated factors are improving.
- Provided a workshop on "Case Planning with Teens at the Table" at the 2016 annual Child Protection Summit. This workshop addressed the common concerns, myths, and barriers that impede the full participation of youth in case planning and case planning meetings. Members of Florida Youth SHINE participated in a panel discussion to address common concerns and share their experiences.
- Working in conjunction with the Case Management Policy workgroup, the Department published a number of new operating procedures with requirements specific to the quality of case management visits with children as follows:

CFOP 170-7, Develop and Manage Safety Plans, published 6/14/2016

11-2. Child, Parent/Legal Guardian and Caregiver Contact Requirements.

a. The primary child welfare professional responsible for the case will continuously assess the family's condition and dynamics in order to determine that the safety plan is dependable, sufficient and reflects the least intrusive actions necessary to protect the child.

b. When a child is in an out-of-home safety plan in a different jurisdiction, the child welfare professional with primary responsibility is responsible for communicating with the secondary worker involved to learn how the child and caregiver are doing, determine if there are actions needed and to share information about parent(s)/legal guardian(s) progress in meeting Conditions for Return.

c. The safety plan will be monitored by the child welfare professional responsible based on the following minimum contact requirements unless the safety plan for the family requires more frequent contact. All child contacts will include observations and private discussion with the child as to the child's safety in their home or placement and the child's well-being.

d. When a child is with a parent/legal guardian in a certified domestic violence shelter or a residential treatment program, the child welfare professional will coordinate any required contacts with program staff and contacts may occur outside of the facility.

e. If a child is on runaway status or his or her whereabouts are unknown, the child welfare professional shall meet the requirements of Rule 65C-30.019, F.A.C.

f. Initial face-to-face contacts with the child and caregiver willl occur at least once every seven (7) days as follows:

(1) For all in-home safety plans, face-to-face contacts every seven days with the child and caregiver will be conducted for the first 30 days from the time the plan was established.

(2) For all out-of-home plans, face-to-face contacts with the child and caregiver will be conducted as long as the child in an out-of-home plan remains in shelter status.

g. After case transfer, the case manager will:

(1) Provide initial face-to-face contact with child(ren) within two working days of case transfer or the date of court supervision, whichever is earlier [Rule 65C-30.007(1)(b), F.A.C.].

(2) Within five business days after the case is transferred from investigations or another case manager, confirm that the ongoing safety plan is sufficient.

(3) Modify the frequency of face-to-face contact while the child is in shelter status only after the case manager's supervisor documents in FSFN that all of the following conditions have been met:

(a) The child is in the care of a relative, non-relative, or a licensed foster parent and is not demonstrating any behaviors that may lead to a placement disruption.

(b) The child has not experienced any placement changes and the case has been open to case management for more than 30 days.

(c) The child's needs have been assessed and all therapeutic services needed are being provided.

(d) The child, if developmentally appropriate, and the out-of-home caregiver are in agreement with the modification to the frequency of contact with the case manager.

(4) Provide face-to-face contact with every child under supervision and living in Florida no less frequently than every 30 days in the child's residence. If the child lives in a county other than the county of jurisdiction, this shall be accomplished as provided in Rule 65C-30.018, F.A.C.

(5) Make an unannounced visit to the child's current place of residence at least every 90 days or more frequently if warranted based on the safety plan.

CFOP 170-9, Family Assessment and Case Planning, published May 11, 2016

5-3 Co-Constructing a Case Plan with Parent(s)/Legal Guardians and Child(ren)

Note: *This section of operating procedure is mentioned as the case manager needs to understand the importance of private conversations with children to invite their input, and when required, work with the child on direct participation in case planning [section 475(1)(B) (42 U.S.C. 675(1)(B)]. These conversations contribute to both the quality of child engagement and the quality of child visits.*

a. The case manager will co-construct the case plan with parent/legal guardian(s). Per s. 39.6011(1)(a), F.S., the case plan must be developed in a face-to-face conference with the parent/legal guardian of the child, any court-appointed guardian ad litem, and if appropriate, the child and temporary custodian of the child. Family Team Conferencing, utilizing a trained facilitator, is considered best practice.

b. In cases involving intimate partner violence, the case manager will discuss with the survivor any safety precautions necessary for the case plan conference, including whether it should be held jointly with the perpetrator.

c. The case manager should discuss with the family who they would like to invite to the meeting, including the possible benefits of having any of the children in the family participate in the meeting.

d. Children 14 years of age and older must be allowed to actively participate in the development of their own case plan, as well as any revision or addition to the plan. Their participation in the actual case plan conference should be based on discussions and feedback from the child and parent/legal guardian.

(1) The child may find it helpful to include persons of their choice in discussions about the child's needs and case plan options to address those needs. Up to 2 members of the case planning team may be chosen by the child unless the case manager, after consultation with a supervisor, believes that such individual would not act in the best interests of the child [section 475(1)(B) (42 U.S.C. 675(1)(B)].

(2) Per s. 39.6035, F.S., children who are 17 years of age and older must participate in the development of the transition plan which must be in place six months after the child's seventeenth birthday.

e. Prior to a case plan conference, the case manager should discuss with the parent/legal guardians and children if attending the conference:

(1) What will occur during the conference.

(2) What the agency, parent/legal guardians and children, if attending the conference, hope to accomplish at the conference.

(3) Possible family conflicts that might arise and ways to ensure that all family members can freely participate.

(4) To the extent possible, the date, time and location of the case plan conference.

6-2. Purposeful Case Management Contacts.

d. Monitoring activities of the case manager to evaluate family progress include but are not limited to the following:

(1) For the child, gathering information to determine whether the child's medical, mental health and/or developmental needs are being adequately addressed by the parent(s)/legal guardian(s) and the parents and/or any other caregivers are getting the child to necessary appointments and accessing identified resources. This includes the following:

(a) Have a conversation with a verbal child; the focus of the conversation should be the child's feelings regarding his or her safety in the home or current placement.

(b) Getting feedback from the child as to whether they are visiting the persons that they wish to see, with adequate frequency and quality of the visitation setting and transportation arrangements.

(c) Providing the child with information that is age-appropriate as to the progress of their parent(s)/legal guardians, case plan goals and outcomes.

(d) Assessing the quality of the child's placement setting in terms of meeting their basic needs for care including routine health care and supervision.

(e) Assessing whether the child's special medical or mental health and educational needs are being adequately addressed. Additional information may be needed from treatment providers or other persons to assess the whether the child's special medical and mental health needs are being adequately addressed. The child's school attendance, review of school records and any educational assessment may be necessary to ensure the child's educational needs are met.

(f) Determining whether the out-of-home caregiver for the child has any needs for support, including services or training that might be critical to the child's placement stability.

Future Plans

- Implement Goal 3, Strategy A, Key Activity specific to quality visits as part of the PIP in response to CFSR 2016 findings about the quality of caseworker visits with children.
- Continue to fund the Florida Study of Professionals and widely disseminate the findings to Florida stakeholders responsible for the retention of child welfare professionals.

CHAPTER VII. Florida's Title IV-E Waiver Demonstration

In October 2006, Florida received flexibility through a five-year federal waiver so funding could follow the child instead of the placement of the child. As the only state with such a broad federal waiver, Florida dedicated resources to keeping more families together and helping parents change their lives and make their homes safe so they can keep or reunify with their children. The flexibility puts funding in line with the program goals of maintaining the safety and well-being of children and enhancing permanency by providing services that help families remain intact whenever possible. The Waiver Demonstration Project continues through September 2018.

Florida's flexible Title IV-E funds allow the Department and its partner lead agencies to create a broader array of community-based services and supports for children and families. Funding supports child welfare practice, program, and system improvements that will continue to promote child safety, prevent out-of-home placement, expedite permanency and improve child and family well-being. This strategic use of the funds allows community-based lead agencies to implement individualized approaches that emphasize both family engagement and child-centered interventions. The waiver demonstration project serves as a catalyst for systemic improvement efforts.

The design of Florida's waiver demonstration project is to determine whether flexibility of Title IV-E funding would support changes in the state's service delivery model, maintain cost neutrality to the federal government, maintain safety, and improve permanency and well-being outcomes. The basis of the theory of change is federal and state expectations of the intended outcomes of the waiver demonstration, and the hypotheses about practice changes developed from knowledge of the unique child welfare service arrangements throughout the state.

The expectation is that the waiver renewal will build on the lessons learned and progress made in Florida's child welfare system of care during the initial waiver period. The goals of the waiver demonstration are to:

- Improve child and family outcomes through the flexible use of Title IV-E funds;
- Provide a broader array of community-based services, and increase the number of children eligible for services;
- Reduce administrative costs by removing current restrictions on Title IV-E eligibility and on the types of services that may be paid for using Title IV-E funds.

Over the life of the waiver demonstration, the expectation is fewer children will need to enter out-of-home care and stays in out-of-home care will be shorter, resulting in fewer total days in out-of-home care. Costs associated with out-of-home care are expected to decrease following waiver implementation, while costs associated with in-home services and prevention will increase, although no new dollars will be spent because of waiver demonstration implementation.

The context for Florida's waiver demonstration renewal is the continued implementation of the child welfare practice model which provides a set of core constructs for determining when children are unsafe, the risk of subsequent harm to the child and strategies to engage caregivers in achieving change. These core constructs are shared by child welfare professionals (child protective investigators, child welfare case

managers and their supervisors), and community-based providers of substance abuse, mental health, and domestic violence services. Other key contextual factors include the role of Community-based Care lead agencies as key partners with shared local accountability in the delivery of child welfare services as well as the broader system partners including the judicial system. The assumption is that implementation of the child welfare practice model will enhance the skills of child welfare professionals in assessing safety, risk of subsequent harm and strategies to engage caregivers in enhancing their protective capacities including the appropriate selection and implementation of community-based services.

Waiver implementation continues the flexible use of IV-E funds. The flexibility allows allocation of these funds toward services to prevent or shorten the length of child placements into out-of-home care or prevent abuse and re-abuse. The Department has developed a typology of Florida's service array that categorizes services into four categories: family support services, safety management services, treatment services, and child well-being services. The services available through the four categories include objectives as well as guidance regarding the conditions when services are voluntary vs. when services are mandated and non-negotiable.

Consistent with the CBC model, each lead agency uses the flexibility differently, based on the unique needs of the communities they serve. The Department is continuing to assess and analyze the availability of the service array in partnership with the CBCs and the case management organizations. Although there is a wide array of services available across the state, improvements are necessary in the availability and accessibility of some critical services in the more rural areas and with ensuring that the services available are in alignment with the new practice model. The strengths and challenges identified vary by service area; however, the identified challenges related to the service array that are consistent statewide:

- Lack of safety management service array for duration of safety management. While most areas identified safety management service providers for the investigation portion of safety management, very few areas in the state have created safety management services for ongoing case management.

- Services are provided without change in delivery or reporting of behavior change. Some of the safety management providers continued to provide the same service previously identified as a diversion, prevention, or treatment service without shifting their service provision to match the need for safety management.

To address this, the Office of Child Welfare (OCW) is conducting a thorough service array assessment that will capture service providers in the state and evaluate their services. Specifically, the assessment includes whether the service is evidence-based and who is the target population for each service. This information will inform the development of a standardized array of services to align with the practice model. Of particular note is the expansion of the model courts evidence-based parenting initiative. This evidence-based program is in 13 of the 20 circuits including the 11th circuit (Miami-Dade) and the 20th circuit (Collier County).

The Department has initiated this assessment through a priority of effort focused on gathering a baseline assessment on services in each services domain established in alignment with the child welfare practice model. During the report period, OCW determined baselines for safety management services and prevention based family support services.

A statewide oversight committee guides and oversees the implementation of the extended waiver period. Throughout the initial five-year demonstration period and continuing, stakeholder buy-in and participant collaboration are vital components for the continued success of Florida's demonstration project. Ongoing efforts occur to make sure that Florida's community is aware of the waiver demonstration.

The waiver extension focuses on aspects of well-being that are crucial to child and family development. Florida will test the hypothesis that capacity building, system integration and leveraging the involvement of community resources and partners yield improvements in the lives of children and their families.

Update/Accomplishments

- A statewide meeting with eligibility specialists convened in June 2016. Eligibility was the focus of the June 2016 statewide meeting - the importance of timely and accurate eligibility determinations and the relationship to the demonstration waiver.
- The 2017 Statewide Eligibility Conference convened in May 2017. Workshops targeted working in collaboration with other state agencies for the administration of Medicaid services to children, properly determining IV-E eligibility for children, and many other topics requested by eligibility staff.
- At the Florida Coalition for Children's Annual Conference in July 2016, the Department conducted a workshop to teach the basics of how child welfare is funded in Florida plus a look ahead at potential Title IV-E/IV-B finance reform.
- The Department collaborated with various partners and consultants concerning strategies to sustain the waiver interventions after the Demonstration waiver period. A Path Forward workgroup comprised of senior leadership, program experts and consultants will lead the initiative.
- Completion of the Florida Title IV-E Waiver Demonstration Evaluation Interim Evaluation Report (10/01/2013 – 3-31-2016). The Interim Evaluation Report offered policy and practice recommendation for which activities are underway. Refer to the Phase 3- Florida's Title IV-E Demonstration Waiver Interim Evaluation Report and the Phase 4- Florida Title IV-E Waiver Demonstration Evaluation Semi-Annual Progress Report located http://centerforchildwelfare.fmhi.usf.edu/DataReports/IVEReport.shtml

Future Plans

- Implement the project plan for the Path Forward initiative to identify strategies for sustaining waiver interventions following the Demonstration waiver period. The Path Forward workgroup is comprised of senior leadership, program experts, and consultants.
- Continue to address the recommendations from the Florida Title IV-E Waiver Demonstration Evaluation Interim Evaluation Report (10/01/2013 – 3-31-2016). Refer to the Phase 3- Florida's Title IV-E Demonstration Waiver Interim Evaluation Report and the September 2016 Semi Annual Progress Report (4-2016 through 9-30-2016). The link to these reports is: http://centerforchildwelfare.fmhi.usf.edu/DataReports/IVEReport.shtml
- Continue to educate Community-based Care (CBC) lead agency executives about the demonstration waiver and importance of ongoing eligibility.

- Increase the availability and access to child welfare services. The Secretary of the Department of Children and Families identified expansion of services as a Priority of Effort (POE) focus area. In an effort to address service gaps at the local level, activities are occurring across the state.

CHAPTER VIII. Child Abuse Prevention and Treatment Act (CAPTA): State Annual Update

This chapter serves as the application for Florida's Child Abuse Prevention and Treatment Act (CAPTA) funding. The chapter includes current activities and accomplishments during the reporting period, and the annual data report (in Appendix A).

The goals and objectives pertaining to the Child Abuse and Prevention and Treatment Act (CAPTA) Plan remain consistent with the Child and Family Services Five Year Plan (CFSP), 2015-2019.There are no substantive changes in Florida Statutes that adversely affect the state's eligibility for the CAPTA State grant.

It is paramount that children are, first and foremost, protected from abuse and neglect. The Florida Department of Children and Families, with primary support from the Office of Child Welfare, continues to be the lead agency designated to administer the Child Abuse and Prevention and Treatment Act grant funds. The Office of Child Welfare is also the designated lead agency for the Community-Based Child Abuse Prevention (CBCAP) federal grant and the Children's Justice Act (CJA) grant. This oversight affords technical assistance for the implementation of evidenced-based and other effective practices and for the development of systemic approaches to outcome improvement at both the state and local community levels.

This continuity in lead agency designation facilitates and promotes achievement of the following defined statewide objectives:

- Prevent children from experiencing abuse or neglect.
- Ensure the safety of children through improved investigative processes.
- Ensure the safety of children while preserving the family structure.

CAPTA ACTIVITIES AND ACCOMPLISHMENTS

Overview

The state continues to develop, strengthen and support prevention and intervention services in the public and private sectors to address child abuse and neglect. Because of Florida's multi-ethnic and multi-cultural state population, the Department and the Executive Office of the Governor have addressed Section 106 (a) of CAPTA through community-based plans and services. Florida funds a multitude of unique community-based services designed by community groups and delivered by child welfare professionals. Each Community-Based Care Lead Agency (CBC) under contract with the Department will continue to use CAPTA funds to support case management, service delivery, and ongoing case monitoring in its area. The array of services includes in-home supports, counseling, parent education, Family Team Conferencing, homemaker services and support groups. In addition to the CAPTA funds, the Department uses a blended and braided funding approach to accomplish the full child welfare continuum of services. Both federal funds specific for child welfare and state funds (general revenue and trust funds) are also utilized to accomplish the goals and objectives of the overall system of care. Prevention services are delivered at the primary, secondary and tertiary levels and treatment interventions are designed to prevent the reoccurrence of child abuse and neglect. Both federal and state monies are used to fund the prevention services.

There have been no significant changes from the state's previously approved 2013 state plan. Florida continued to target the same service program areas defined in the CAPTA State Plan 2013. They are as follows:

- Intake, assessment, screening, and investigation of reports of abuse and neglect (106 (a) (1))
- Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families (106 (a) (3))
- Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols (106 (a) (4))
- Developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange (106 (a) (5))
- Developing, strengthening, and facilitating training (106 (a) (6))
- Developing and facilitating research-based strategies for training individuals mandated to report child abuse or neglect (106 (a) (8))
- Developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect (106 (a) (11))
- Supporting and enhancing collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems) and to address the health needs, including mental health needs, of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports(106 (a) (14)).

Florida will commit annually to report on additional progress as it relates to the other CAPTA program areas, if applicable.

Activities and Accomplishments Related to Plan Requirements

PART C

The Child Abuse Prevention and Treatment Act (CAPTA) has a significant requirement for States to have provisions and procedures for the referral of children under the age of three who are involved in substantiated cases of child abuse or neglect to early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA) [42 U.S.C. 5106a, Sec. 106(b)(2)(A)(xxi)]. Florida has defined "substantiated" as any case with verified findings of child abuse or neglect.

The Department of Health (DOH) is the state's lead agency and has the primary responsibility of delivering services under Part C in Florida. However, there are activities and services where collaboration between the Department of Children and Families and the Department of Health is essential.

Florida's Early Steps program is designed to ensure that children under the age of three who are involved in substantiated cases of child abuse or neglect and are potentially eligible for early intervention services are referred for assessment and potential services.

The Florida Interagency Coordinating Council for Infants and Toddlers (FICCIT) is authorized and required by Part C of the Individuals with Disabilities Education Act (IDEA) as amended by Public Law 105-17. The role of FICCIT is to assist public and private agencies in implementing a statewide system of coordinated, comprehensive, multidisciplinary, interagency programs providing appropriate early intervention services to infants and toddlers with disabilities and risk conditions and their families. The Department of Health is the lead agency for this council, as well, and this represents one of the more critical partnerships for young children for the Department of Children and Families.

2015-2016

The FICCIT plays a very important role in managing and coordinating services for children and their families in the state of Florida. The following are some of, but not exclusively, the responsibilities of the FICCIT:

- Assist and advise the lead agency (DOH) in coordinating activities for the planning and preparation of IDEA applications and amendments, as appropriate.
- Provide advice and assistance to the lead agency in the development of policy and definitions for the minimum components of Public Law 102-119, IDEA, Part C.
- Assist in the preparation and submission of an annual report on the status of Early Intervention Programs for infants and toddlers with disabilities and risk conditions and their families.
- Recommend procedures for distribution of funds and priorities for program support under Part C of the IDEA as amended by Public Law 102-119.
- Assist the lead agency in developing and reporting information and evaluations of programs for infants and toddlers with disabilities and risk conditions and their families.
- Assist the lead agency in seeking information from service providers, service coordinators, parents and others about any federal, state, or local policies that impede timely service.
- Conduct meetings on a quarterly basis at various locations throughout the state. The meetings are open to the general public.

Accomplishments

By working with the FICCIT, the Department has established a stronger relationship with DOH enabling them to better meet the needs of both parents and children with disabilities.

Collaboration

One of FICCIT's primary goals is to foster collaboration between Early Steps programs and other state, public, and private agencies.

Program Support

Three agency staff are appointed to the FICCIT to support that all potentially eligible children are identified and referred for early screening for disabilities. The three representatives are from the Child Care Program Office, Office of Child Welfare, and Substance Abuse and Mental Health Program Office.

CHILDREN'S JUSTICE ACT (CJA)

2015-2016 Update

Florida has been a Children's Justice Act (CJA) grant recipient since 1997. These funds have allowed for the development, implementation, and review of projects that have the potential to have a significant impact on the child protection response system. Therefore, Florida's child welfare system continues to benefit from the CJA grant by providing education, training and reform.

Eleven projects were completed during the FFY 2015 - 2016 reporting period. A summary of the completed projects funded by the CJA Grant during the reporting period is provided below.

1. **2016 Annual Child Protection Summit**
   $207,093 (Scholarships to attend for Investigators, Children's Legal Services, and Law Enforcement)

   The Summit provides support and technical assistance to those on the front end of child welfare, offering an opportunity to attend sessions designed to improve and strengthen the knowledge base and specialties of child protective investigators and their supervisors.

   In previous years, over 2,500 child welfare professionals attended the Summit which offers opportunities for collaboration and professional development. Learning opportunities include: Human Trafficking; Court Testimony and Evidence Gathering; Domestic Violence; and many others. The Summit provides a critical forum for development of professional competencies for Child Protective Investigators. Multiple task force members participate in workshop vetting, selection, and summit planning.

2. **2016 8th Annual Child Abuse and Neglect Conference**
   $30,000 (200 scholarships)

   The 2016 Child Abuse and Neglect Conference focused on the medical aspects of child physical abuse, sexual abuse and neglect. The conference content provides an understanding of the mechanisms that inflict injuries and the scientific basis for medical determinations as to whether abuse has or has not occurred. The speakers stress the roles of all members of the investigative team in gathering and sharing information to arrive at appropriate conclusions. The Department, through the Children's Justice Act Grant, has offered scholarships to child protective investigators, child protective investigator supervisors, and CLS attorneys.

   This is the only conference of its type presented in Florida focusing on the medical aspects of child abuse and neglect. The conference's objective is to increase the knowledge base of non-medical personnel in all professions dealing with the investigation of allegations of abuse and neglect, interventions to protect abused and neglected children, and the prosecution of perpetrators. The goal of the conference is to improve the investigative capabilities and understanding of the medical issues, resulting in enhanced communication among community partners to improve the outcomes for children. Participants are able to receive Continuing Education Units (CEUs) and Continuing Legal Education credits (CLEs) approved through the Florida Certification Board and the Florida Bar.

3. **Florida Justice Technology Center (FJTC)**
   $131,000

   A pivotal event in an abused child's life is the court case where the child's future is determined. Too often, the judges, attorneys, and others involved lack the tools, resources, and training necessary to achieve the best outcome for the child. Increasing use of FLORIDA for Children and Families as well as other FJTC portals will result in more positive outcomes for abused and neglected children by providing resources and important information to parents, guardians ad litem, attorneys and judges advocating for children in the courtroom.

   CJA funds provide a content expert for the Florida Justice Technology Center to develop content for FLORIDA for Children and Families (www.F4CF.org), as well as fund its license.

4. **University of South Florida, Florida's Center for Child Welfare, Child Welfare Policy Mobile Application**
   $100,500

   The Office of Child Welfare is designing and building a mobile application for Child Welfare Professionals in the State of Florida to utilize on all Android and iOS devices. Within the mobile application the following features will be available to Child Protective Investigators:

   - Child Welfare Resource Web Page, containing hyperlinks to Florida Statute, Florida Administrative Code and numerous other existing websites.
   - Frequently Asked Questions (FAQs)
   - User friendly searchable module for eight of the Department's Child Welfare Operating Procedures

5. **Early Childhood Court Strengthening**
   $36,320

   Meetings served two purposes: 1) to provide continued training and technical assistance for Florida's Early Childhood Court (ECC) Community Coordinators, and 2) to enhance the understanding of the ECC Core Components pertaining to the needs of young children involved in child welfare among key partners. There are 17 ECC courts up and running throughout the state. Court teams are beginning to experience some challenges involving the core components of ECC around system changes. Meetings focused on supporting ongoing collaboration and making sure the team continues to view cases through the eyes of the child.

6. **Human Trafficking Training**
   $13,350

   Training provided specialized child protection training for investigators and other child welfare professionals who work with children who are victims of human trafficking. This project sought to improve child welfare practice related to the investigation and prosecution of cases of child sexual abuse and exploitation. Attendees learned techniques to assess for and identify human trafficking victims, techniques for identifying and for responding to gang led trafficking.

7. **Preventing Crimes in Black Communities Conference**
   $5,000

   The 31st National Preventing Crime in the Black Community Conference was a collaborative effort sponsored by Attorney General Pam Bondi to foster communication and action among practitioners through the sharing of innovative ideas and prevention strategies that have been successful in the black community. A major component of the program highlighted alternatives to violence among our young people. The agenda was designed to showcase successful programs and promote the positive exchange of ideas on the subject. Over 1300 people attended the conference in Miami.

8. **Printing and Binding of Chapter 39 of the Florida Statutes for Child Welfare Professionals**
   $31,838

   Child Protective Investigators, Children's Legal Services and Guardians ad Litem need to have quick and immediate access to Florida State Statute. With the printing and binding of statute relevant to child welfare procedure, staff are now able to carry this information with them to court, multidisciplinary staffings, and other work settings. It is essential for staff to have quick and immediate access to statutory mandates. This successful printing and distribution throughout the state was appreciated by front line staff.

9. **Four Regional Competency Events for Child Protective Investigation Supervisors**
   $75,000

   The Office of Child Welfare, in partnership with the Statewide Supervisor Support Team, hosted four regional Supervisor Conferences from April – June, 2016. These events provided skill building workshops on supervisory consultation and leadership skills. The presentations were a combination of application based activities focusing on the correct use of safety methodology principles during consultative sessions with their staff and process activities exploring how supervisors can facilitate decision-making in staff by modeling (i.e., demonstrating) the use of open ended questions (instead of providing task specific directives) during consultative interactions. Workshop discussion material included assessment of caregiver protective capacity, risk assessment scoring and engaging high and very high risk families in family support services, assessing condition for return, and teambuilding exercises for staff. Each regional event provided four different sessions over two consecutive days. Each event accommodated approximately 100-150 participants.

   Event 1 - Central Region, Orlando, April 21-22

   Event 2 – Southeast/Southern Regions, Ft. Lauderdale, June 8-9

   Event 3 – Northwest/Northeast Regions, Destin, May 24-25

   Event 4 – SunCoast Region, Tampa, June 28-29

10. **Florida State University, Child Protective Investigator Review**
    $68,000

    Because of the high, ongoing turnover in child protection staff, a workforce study was identified as a significant need. This study consists of a 5-year longitudinal study of newly hired Child Protective Investigators (CPIs). The study focuses on research questions about retention and child/family outcomes including:

- Do educational differences at the time of hiring impact family and child outcomes along with retention?
- At what point do investigators start to consider leaving their positions?
- How long does it take front-line staff to leave once they begin considering alternative options?
- If they chose not to leave, what made them stay?
- Once someone has stated an intention to leave their employment, are there any strategies that could prevent that from occurring?
- How does child welfare work affect personal lives and does this influence decisions around leaving?
- What management practices influence decisions around leaving or staying?
- What workload issues most impact job satisfaction and do those change over time?
- Do investigators who leave their positions also leave the profession of child welfare?
- What do they do instead of child welfare?
- What investigator or organizational characteristics influence turnover as compared to retention?

11. Assessment, training development and training for child protective investigators in use and documentation of FSFN to help ensure safety of children.
$75,000

Use of Florida Safe Families Network (FSFN), the state's SACWIS system and electronic file of record, has not realized its full potential, due in part to the limited user training during pre-service training. This impacts not only the quality of case specific outcomes but also the quality of data needed to make programmatic, predictive, administrative, and operational decisions. To improve individual user and overall system performance, CJA funds supported training for front line Child Protective investigators in the understanding and full utilization of FSFN.

Collaboration

- Through the Task Force and the Department's leadership, the training content for the 2016 Summit was chosen after consultation with stakeholders and child welfare professionals throughout the State of Florida. A call for workshop proposals was widely disseminated and over 100 proposals received.
- Through the Task Force, and the Department's leadership, the statewide implementation of the child welfare practice model requires collaboration with a variety of stakeholders and other state agencies in every county in Florida.
- The Department of Children and Families' leadership and subject matter experts have met with and worked with a wide variety of stakeholders on the topics of human trafficking, domestic violence, and child fatalities throughout the reporting period.

Program Support

In partnership with CBC lead agencies and child welfare professionals, the continuing implementation, fidelity, and sustainability of the child welfare practice model will ensure that children and their families are receiving in-depth, quality assessments and relevant individualized services.

Community-Based Child Abuse Prevention Program (CBCAP)

2015-2016 Update

Florida received a Federal Fiscal Year (FFY) 2015 Federal Community-Based Child Abuse Prevention Program (CBCAP) grant award of $ 1,492,750 based on Florida's child population and matching funds through the state's Tobacco Settlement Trust Fund. A variety of family-focused programs and services enhance the prevention of child abuse and neglect. The previously allocated funds supported continuation of prevention programs through training, network administration, and educational materials. Allocated funds supported a continuing contract with the Ounce of Prevention Fund of Florida, Inc., for activities related to the annual child abuse prevention campaign, family support services and parent support.

Statewide and regional projects focus on public awareness and community education initiatives, training for professionals, and support of statewide resources for family violence prevention. CBCAP funds will continue to be directed towards family support services, accessed by families where children are deemed safe but are at high or very high risk for future maltreatment based on an actuarial risk assessment completed by the Child Protective Investigator.

Accomplishments

At the local level, community-based care has increased local community ownership and active involvement in developing an effective and responsive service delivery system and array of services. There are a variety of community based groups developed in response to specific needs of or issues with the community that meet on-going to assess gaps in services and service delivery and take action to address them.

During the reporting period, funded programs provided direct services to more than 23,000 children, caregivers, and other family members. Florida funds community-based services targeting the prevention of child abuse and neglect statewide that address the needs of our multi-ethnic and multi-cultural state population. Families who have children with special needs are also afforded services. Families with children found to be safe but at high or very high risk of future maltreatment are encouraged to participate in family support services, in an effort to strengthen protective factors and prevent maltreatment.

Collaboration

Consistent efforts, to develop, nurture, and expand the scope and array of supportive partners, have had a significant impact on community awareness and action. Many partners and advocates, while working on behalf of families, have experienced the benefits and efficiencies of collaboration. A statewide prevention workgroup is in place, linking various state agencies; the prevention workgroup ensures consistent messaging is taking place. The Department understands collaboration with other partners and stakeholders is an essential element to keeping Florida's children and families safe and free of maltreatment. It is through these collaborations that gaps and limitations in service array and availability are identified and are addressed.

Program Support

The Department contracts with a set of core programs for primary and secondary child abuse prevention services to complement the existing network of additional primary, secondary, and tertiary prevention programs and services. The specialist from the Office of Child Welfare coordinates efforts with providers, communities, state and local leaders and advocates.

Citizens Review Panels

In response to the CAPTA requirements, as required in 42 U.S.C. 5106a, Section 106 (c)(6), the Department has designated three entities as Citizen Review Panels. Each of these meets the requirements of the Child Abuse Prevention and Treatment Act.

The currently designated panels are:

- Independent Living Services Advisory Council;
- Florida Child Abuse Death Review Committee; and
- Florida Faith-Based and Community-Based Advisory Council.

For additional information, activities, recommendations and the required Department responses of these three panels, please refer to their annual reports included as Attachments.

The Independent Living Services Advisory Council (ILSAC)

This Council is legislatively mandated under s. 409.1451(7), Florida Statutes. The functions of ILSAC are to review and make recommendations concerning the implementation and operation of independent living transition services.

2015-2016 Update

During this period, the ILSAC continued to meet its charge by reviewing the system of independent living services for teens in foster care/formerly in foster care in Florida. As mandated in Florida law, the Secretary appoints members who submit an annual report summarizing the Council's findings and recommendations. These reports are available at: http://www.myflfamilies.com/service-programs/independent-living/advisory-council .

Council members have a variety of experiences and are from diverse backgrounds, including young people formerly in foster care. As required by state statute, the Council held four meetings during this period and issued a report for the period ending December 31, 2016. The Annual Report is the Council's primary work product.

Accomplishments

The Council continues to be a strong voice for youth and includes a diverse group of stakeholders to ensure various perspectives are heard. Under the leadership of Jeff DeMario, the ILSAC chairperson, the Council works closely with the Department and the community-based care agencies to improve service delivery.

Collaboration

The council represents a collaborative with youth, foster parents, executive agencies, advocate attorneys, and child welfare service providers.

Program Support

Members of the Council are active in their communities and across the state. They help to provide training and technical assistance to ensure the program is supported at the local and state level. The Department provides staff support to the Council. Both the Council Chair and the members provide advice and consultation to the Secretary, Deputy Secretary, and leadership of child welfare programs.

Future Plans

The Council will continue as it is mandated in Florida law. This Council is a true asset for the youth served in Florida and for the agencies that serve them. The Council members provide guidance and help to improve services in a non-adversarial and supportive manner.

The Florida Child Abuse Death Review Committee

This citizens' committee was established by the Florida Legislature in 1999 under section 383.402, Florida Statutes. The committee is comprised of a statewide appointee panel and locally developed multi-disciplinary teams charged with reviewing, the facts and circumstances surrounding cases in which child fatalities occurred directly as a result of verified maltreatment. The committee prepares an annual report to the governor and legislative branch with key data-driven recommendations for reducing preventable child deaths due to abuse and neglect by caregivers.

This citizens' committee was established by the Florida Legislature in 1999 under s. 383.402, Florida Statutes. Since the inception of the Child Abuse Death Review Committee (CADR) system, changes in statutory requirements have gradually widened the scope of child fatality cases committees are expected to review. In 2016 local committees began reviewing all child fatalities reported to the Florida Abuse Hotline, not just child protective investigation with verified findings. This expanded scope has allowed the state committee to review additional data sets that can be used to inform statewide and local prevention strategies aimed at reducing child abuse and neglect deaths in Florida.

2015-2016 Update

- Enhance and support the integration of behavioral health services into the child welfare system.
- Continue to support programs that enhance parenting skills.
- Ensure clear and consistent messaging among agencies during efforts to increase awareness.
- Encourage collaborative partnerships at both the state and community levels.
- Explore the value and utility of existing prevention activities throughout Florida.
- Support the development of toolkits to assist in the planning and development of prevention activities
- Offer training and technical assistance to circuits regarding how to leverage data to inform and improve practice.

Accomplishments

The State Child Abuse Death Review Committee, with input and participation from local committee members, has reviewed and analyzed data findings to determine next steps for Florida's child maltreatment prevention initiatives. Prevention recommendations are built around data findings, specifically the top three primary causes of child fatalities, as defined by all data sources. This framework provides a solid foundation for targeting and implementing prevention strategies at state and local levels specifically aimed at significant challenges.

Conclusions and Next Steps

Child maltreatment is a critical public health issue with devastating consequences for society as a whole. Efforts to create positive, sustainable change will require a multi-sector approach that sufficiently addresses all levels of the social ecology model, from intervention at the individual level to influencing cultural and societal norms. Overarching prevention strategies at state and local levels can be tailored to address issues clearly identified as chief concerns. Drowning, asphyxia (unsafe sleep), and inflicted trauma continue to be the top three primary causes of preventable deaths in children, and will require well-coordinated efforts that incorporate consistent messaging to address these trends.

To ensure successful outcomes evidence-based prevention programs and practices must be adopted. New and innovative practices that show promise must be evaluated. Florida must continue to improve and expand research efforts, such as the identification of appropriate and available data sets to reach beyond the mere collection of data to ensure that meaningful data analysis ultimately leads to strategic action.

Program Support

The Florida Department of Children and Families provides staff support to the State Death Review Committee and local Child Death Review Committees. This entails preparing child death case files for review purposes and maintaining a database on specific circumstances involving a child death to use for prevention initiatives as well as training for investigators and case managers.

Florida Faith-Based and Community-Based Advisory Council

The Florida Faith-Based and Community-Based Advisory Council (Advisory Council) was created in 2006 in s. 14.31, Florida Statutes. The Florida Faith-Based and Community-Based Advisory Council exists to facilitate connections to strengthen communities and families in the state of Florida. The Council is charged to advise the Governor and the Legislature on policies, priorities and objectives for the state's comprehensive efforts to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community organizations to the full extent permitted by law.

State leadership felt increased involvement of faith-based and community organizations were not a substitute for necessary public funding of services to individuals, families and communities in need. They believed that public expenditures without the involvement of these groups limit the effectiveness of government investments. The cost effectiveness of public expenditures can be improved when government is focused on results and public-private partnerships are used to leverage the talent, commitment and resources of faith-based and community organizations.

During the 2010 Legislative Session, the Sunset requirement for the Advisory Council was repealed through legislation. In addition, the Advisory Council was assigned to the Executive Office of the Governor where it is administratively housed.

2015-2016 Update

On June 12, 2007, the bill creating the Governor's Office of Adoption and Child Protection (Office) was signed into law. The duties and responsibilities of the Office are codified in Florida Statute 39.001. The Office was created for the purpose of establishing, implementing, and monitoring a cross-agency comprehensive statewide approach for the promotion of adoption, support of adoptive families and prevention of child abuse, abandonment and neglect. In October 2011, the Executive Office of the Governor made a decision to move the administrative functions and support for the Advisory Council to the Governor's Office of Adoption and Child Protection.

The Advisory Council website can be found at: www.flgov.com/fbcb

Accomplishments

The Office worked diligently throughout 2016 to advance the efforts of the Advisory Council. The following workgroups to advance the work of the Advisory Council were established:

- Annual Conference
- Child Welfare
- Criminal Justice
- Disaster Planning
- Family Initiatives
- Legislative

Child Welfare Workgroup – The Child Welfare Workgroup assisted to advance efforts to enhance and improve the welfare of children in Florida. The workgroup focused on increasing awareness of prevention, child maltreatment, foster care, adoption, independent living, human trafficking, health and well-being, youth with disabilities, and education. The workgroup coordinated efforts with state agency liaisons and various faith-based and community-based organizations to identify needs, gaps in services, and propose solutions in order to facilitate a more collaborative and coordinated approach to improving outcomes for children and families.

Criminal Justice Workgroup – The Criminal Justice Workgroup supported efforts of the Department of Corrections and Department of Juvenile Justice to improve outcomes for their populations. The workgroup focused on identification of best practices and effective strategies to include prevention, early intervention, diversion and re-entry or reintegration of adults and juveniles from jail and juvenile facilities, substance abuse, mental health, and persons with disabilities. The workgroup will bring together state agency liaisons and various faith-based and community-based organizations to identify needs, gaps in services, and propose solutions in order to facilitate a more collaborative and coordinated approach to working with state government agencies.

Family Initiatives Workgroup – The Family Initiatives Workgroup assisted in advancing efforts to improve family preservation, healthy marriage, fatherhood, single parent families, and other family related issues such as employment and homelessness.

Legislative Workgroup – The Legislative Workgroup works closely with all Advisory Council workgroups to research and identify recommendations to refine, improve, and strengthen policies and legislation affecting Advisory Council workgroup focus areas and faith-based and community-based organizations.

Collaboration

The Florida Faith-Based and Community-Based Advisory Council has collaborated with state agencies as well as community and local organizations to advance its work. With limited state resources, the Florida Faith-Based and Community-Based Advisory Council has utilized various approaches to fulfill statutory requirements and support state initiatives and activities.

Program Support

Champions of Hope Awards

Realizing the value of faith communities and organizations in providing support to the state and state agencies, the Champions of Hope award was created to recognize organizations that go above and beyond the ordinary to improve the lives of at-risk youth and children in care. The Annual Conference Workgroup provided nomination forms to the Department of Children and Families, Juvenile Justice, Health and the Department of Agriculture and Consumer Services for dissemination to regional offices to identify and nominate faith-based organizations for consideration.

Activities and Accomplishments Related to State Plan Program Service Areas: 42 U.S.C. 5106a

The second requirement of the CAPTA grant is to address Florida's three program areas in its state plan. Each of these program areas underpins and was integrated with the Program Improvement Plan (PIP) and the Children and Families Services Review (CFSR), so cross-referencing has been provided where applicable. The goals, objectives and benchmarks of the PIP and CFSR are outlined and updated in Chapter 7 of this report. Subsequent to the successful completion of the PIP, interim goals were described in the Annual Progress and Services Report submitted June 2013 that built on those successes and included new strategic priorities.

In addition to the three state plan program areas, gains in other program areas are briefly described. Note: In this section, the CAPTA program areas are numbered consistent with the structure in Section 5106a of the Act.

(1) Intake, assessment, screening, and investigation of reports of abuse and neglect.

The Department is responsible for conducting child protective investigation in 61 of 67 Florida counties, with sheriffs' offices operating in the remaining 6 counties under grants administered by the Department. Child protective investigators (CPIs) are generally responsible for two types of investigations: in-home investigations for a child residing with his/her parent or caregiver and out-of-home investigations when allegations of abuse/neglect occur while a child is in a Department-licensed facility, child care program, foster home or institution, or when a child is being cared for by an adult caregiver such as an adult sitter

or relative care provider. Areas of the state that receive a large number of out-of-home (i.e., "Institutional") investigations may have a specialized unit that handles only those types of reports.

Florida's new child welfare practice model provides a set of common core constructs for determining when children are unsafe, the risk of subsequent harm and how to engage caregivers in achieving change. To accomplish this, the Hotline gathers information in to determine whether present or impending danger is suspected. The investigator gathers further information related to the six specific information domains and assesses it in order to determine: (1) the presence of danger threats; (2) if a child is vulnerable to the identified threat; and (3) whether there is a non-maltreating parent or legal guardian in the household who has sufficient protective capacities to manage the negative family conditions in the home. The totality of this information and interface of these components are the critical elements in determining whether a child is safe or unsafe and the risk of subsequent harm.

The same core constructs guide actions to protect children (safety management) and support the enhancement of caregiver protective capacities (case planning). The case planning process is based on an understanding of the stages of change and the logical progression that is most likely to result in successful remediation of the family conditions and behaviors that must change.

Florida's child welfare practice includes the expectation that when children are safe and at high or very high risk for future maltreatment, affirmative outreach and efforts will be provided to engage families in family support services designed to prevent future maltreatment. When children are determined to be unsafe, safety management and case planning is non-negotiable. While service interventions are voluntary for children determined to be safe but at high or very high risk of future maltreatment, the investigator should diligently strive to facilitate the parent's understanding of the need for taking action to protect their children from future harm.

The Florida Abuse Hotline

The single entry point to child welfare services in Florida is the Florida Abuse Hotline. The centralized Florida Abuse Hotline located in Tallahassee operates twenty-four hours a day, seven days a week. Reports can be placed via the toll free telephone number (1-800-96-ABUSE), including through telecommunication devices for the deaf and hard of hearing; by fax; and electronically via the Department's internet website.

Florida Abuse Hotline counselors assign response times (Immediate or 24-hour) to reports based upon the assessment that the child's immediate safety or well-being is threatened. In addition, Hotline staff provide child protective investigators important criminal and child welfare history prior to their arrival at the home to improve safety assessments and front-end decision-making.

Assessment, Screening, and Special Conditions

Florida recognizes that incidents with serious safety concerns should receive complete and comprehensive child protective investigations. However, some situations reported to the Department do not allege abuse, abandonment or neglect and are more appropriately addressed by the provision of resources or services outside of the child protection system.

For example, situations reported to the Florida Abuse Hotline that do not rise to the level of a protective investigation may be addressed as a "prevention referral." This practice is designed to give the Department an opportunity to help communities identify and provide services for families in order to avoid formal entrance into the child welfare system. The Department tracks and monitors such prevention referrals, which are called "Parent in Need of Assistance."

On July 1, 2014 the Florida Abuse Hotline was transitioned from Operations to the Office of Child Welfare. As a part of this transition, two positions were created within the Office of Child Welfare to provide support to Hotline Operations. The first was a Hotline Policy and Practice Specialist who works closely with the Child Protective Investigative and Case Management Specialists to ensure the development of seamless policy that supports our Child Welfare Practice. Similarly, a Continuous Quality Improvement Specialist for the Hotline was created to review and assess the handling of calls by Hotline counselors and the decision to screen out or accept a report based upon the sufficiency of the information obtained by the counselor.

Within Hotline Operations, the management team was updated to include a Fidelity Team and a Practice Team. The Fidelity Team encompasses Quality Assurance, Training and the Hotline Specialists. The Practice Team has responsibility for the call floor. There is also a Data Analytics Team and Human Resources Team.

Criminal Background Checks in Florida

Upon receiving and accepting a report for an allegation of abuse, neglect, and/or abandonment, Hotline counselors generate a report in Florida Safe Family Network, which is then forwarded to Crime Intelligence staff to complete criminal history checks. The complete abuse/neglect report is then forwarded to the appropriate investigative office in the county where the child is physically located or, if the child is out of state, the location the child will reside upon returning to Florida.

Hotline Crime Intelligence staff complete criminal history checks for investigations to include subjects of the investigation for both child and adult abuse reports, other adult household members, and children in the household 12 years or older. Staff also complete criminal history checks for emergency and planned placements of children in Florida's child welfare system.

The type of checks performed and data sources accessed is based on the program requesting the information as well as the purpose of the request (subjects of the investigation or individuals being considered for placement of children). The Florida Abuse Hotline Crime Intelligence staff has access to the following criminal justice, juvenile delinquency, and court data sources and information:

- Florida Crime Information Center (FCIC) – Florida criminal history records and dispositions;
- National Crime Information Center (NCIC) –National criminal history records and dispositions;
- Hotfiles (FCIC/NCIC) – Person and status files such as: wanted person, missing person, sexual predator/offender, protection orders;
- Department of Juvenile Justice (JJIS) – Juvenile arrest history;
- Comprehensive Court Information System (CCIS) – Florida court case information;

- Department of Highway Safety and Motor Vehicles (DAVID) – Driver and Vehicle Information Database current drivers history, license status, photos, signature;
- Department of Corrections (DOC) – current custody status, supervision, incarceration information;
- Justice Exchange Connection– Jail databases for current incarcerations, associated charges, and booking images.

When a CBC is considering a placement option for a child upon removal from his or her home, they must contact the Florida Abuse Hotline, Background Screening Unit, and request criminal history record information on potential caregivers.

For placement checks, fingerprint submissions must be obtained by the investigator or case manager within 10 days for all persons in the placement or potential placement home over the age of 18 years following the Hotline's query of the NCIC database.

By adding statutory language (Chapter 39) on criminal background screening for investigations and placement, the federal requirements are more clearly defined for screening for adoptive parents, relative and non-relative placements.

(2) Multidisciplinary teams and interagency, interstate, and intrastate protocols to enhance investigations; and improve legal preparation and representation

- The Office of Child Welfare completed regional visits to each of the six regions in the state. Each region identified practice areas to focus on and address over both the short-term and long-term. The Office of Child Welfare also identified statewide issues based upon regional input such as the need to focus on increasing safety methodology proficiency of supervisors and managers. The Office of Child Welfare also met with all eighteen (18) Community-based Care providers to assess how their respective service arrays were aligned with the core safety concepts of our practice model. These meetings proved beneficial in identifying both strengths and gaps throughout the state and the need for further assessment.
- Following the initial visits, each Community-based Care provider completed a self-assessment of their Family Support and Safety Management service array. Data collected was used to provide a baseline with the specific focus on family support services for safe children and to gain a better understanding of the formal and informal safety management services currently being provided. Based on the preliminary results of the service array survey, the Department identified a need for additional Family Support Services throughout the State, including services provided to families who have been identified as at-risk for abuse or neglect through community referrals, assessments, or calls received by the Florida Abuse Hotline.
- Considerable work was accomplished during this time converting practice guidelines and combining existing Family Safety operating procedures into a cogent, comprehensive set of new Child Welfare Practice operating procedures. Here is a list of the more substantive work, by order of release date:
    - 'Child Maltreatment Index' (CFOP 175-28) superseded in its entirety by 'Child Maltreatment Index' (CFOP 170-4), February 25, 2016

- ‘Completing Hotline Intake Assessment’ (CFOP 170-2), April 4, 2016
- ‘Additional and Supplemental Reports’ (CFOP 175-25) superseded by Chapter 4
- ‘Duplicate and Sequence Merges’ (CFOP 175-46) superseded by Chapter 8
- ‘Child Protective Investigations’ Florida Safety Methodology Guidelines superseded by ‘Child Protective Investigations’ (CFOP 170-5), April 4, 2016
- ‘Investigative Response’ (CFOP 175-21) superseded throughout numerous chapters
- ‘Hospital Emergency Room with Child Abuse Reports’ (CFOP 175-69) superseded by Chapter 9
- ‘Reports Involving Allegations of Medical Neglect of an Infant With Life Threatening Conditions’ (CFOP 175-49) superseded by Chapters 5 and 9
- ‘Termination of Services’ (CFOP 175-47) superseded by Chapter 9
- ‘Family Assessment and Case Planning’ (CFOP 170-9), May 11, 2016
- ‘All Staff’ Florida Safety Methodology Guidelines superseded by ‘Florida’s Child Welfare Practice Model’ (CFOP 170-1), May 30, 2016
- ‘Case Chronological Documentation’ (CFOP 175-42) superseded by Chapter 12
- ‘Sharing Records with Children’ (CFOP 175-37) superseded by Chapter 13
- ‘New Children in Families with Active Investigations or Case Services’ (CFOP 175-72) superseded by Chapter 9
- ‘Develop and Manage Safety Plans‘ (CFOP 170-7), June 14, 2016
- ‘Reunification’ (CFOP 175-38) superseded by Chapters 9 and 12
- ‘Intakes and Investigative Response to the Human Trafficking of Children (CFOP 175-14) superseded in its entirety by ‘Response to the Human Trafficking of Children’ (CFOP 170-14), July 1, 2016
- ‘Federal and State Funding Eligibility’ (CFOP 175-71) superseded in its entirety by ‘Federal and State Funding Eligibility’ (CFOP 170-15), August 8, 2016

- Action for Child Protection completed 397 case reviews to assess implementation of the safety methodology with fidelity.
- Additionally, the Department collaborated with the Institute for Child Welfare and Action for Child Protection to begin an inter-rater reliability study of the rating of the caregiver protective capacities. The projected completion date for this review was postponed until fiscal year 2017 due to delays in getting the contract completed during the October 2015-Septembr 2016 period.
- As part of the Structured Decision Making® (SDM) initial risk assessment’s implementation, NCCD Children’s Research Center (CRC) will complete case reviews for completed risk assessments and related narrative documentation to identify staff strengths and issues with the risk assessment completion. The projected completion date of this study was postponed until fiscal year 2017. The contract language is being re-written to more specifically describe the structure and content of the cases to be reviewed to improve the assessment of fidelity.

- The Office of Child Welfare sponsored four statewide regionally based two-day supervisory training conferences for child protective investigation and case manager supervisors during this reporting period. In addition to an opening plenary session at each of the four conferences that focused on the importance of leadership in child welfare four workshops were offered to participants: Team Building, Motivational Interviewing, Improving Supervisor Consultations and Assessment of Caregiver Protective Capacities. The conferences dates were as follows:
    - Central Region – April 21 and 22, 2016
    - Northwest and Northeast Regions - May 24 and 25, 2016
    - Southeast and Southern Regions – June 8 and 9, 2016
    - Suncoast Region – June 29 and 30, 2016
- The safety methodology proficiency credentialing process was completed in conjunction with Action for Child Protection, Inc., and can be found on the Florida's Center for Child Welfare website under the Results-Oriented Accountability tab, "Windows into Practice – Guidelines for Quality Assurance Reviews."

(3) Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families.

When child protective investigation indicates that parents or guardians are unable to protect their children (the child is "unsafe"), the Department provides a full spectrum of services aligned with a safety plan. In-home safety plan services are emphasized in order to keep children safe in their home whenever possible to do so. Florida's child welfare practice emphasizes the least intrusive approach with the family while keeping the safety of the child as the paramount concern.

The Office of Child Welfare published a new operating procedure, CFOP 170-9, Family Assessment and Case Planning, May 11, 2016. This resulted from a lengthy development process involving the statewide Case Management Policy workgroup. This operating procedure provides comprehensive statewide standards for family engagement during every stage of a child welfare case that has been transferred to the CBC/Lead Agency. The standards provide for the on-going assessment of caregiver protective capacities and child well-being indicators whether the case involves in-home protective services or out of home care. The standards for family engagement include child and family assessment, identifying family change strategies and barriers to change, co-constructing case plans and collaborating in the on-going assessment of progress.

Prior to the implementation of the new practice model, there were not consistent statewide standards provided to determine when in-home services were appropriate, or when out-of-home care was necessary. CFOP 170-7, Chapter 4, published in June 2016 establishes clear and specific guidance for determining whether it is safe to create an in-home safety plan with protective supervision. A "Safety Analysis" is prepared at the conclusion of an FFA-Investigation, FFA-Ongoing or Progress Update that summarizes the conditions in the home. There are five criteria that family conditions must meet in order for a child welfare professional to establish an in-home safety plan. If any of the criteria for an in-home safety plan are not met, the child must be placed out-of-the home. Conditions for Return are established to clarify what family condition must change, what it must look like, in order for an in-home plan to be

created and the child reunified. After reunification, the child will have an in-home safety plan and the family will continue to receive the services necessary to help them achieve their case plan outcomes.

CFOP 170-7 in Chapter 8 also establishes safety management service categories and types (Behavior Management, Crises Management, Social Connections, Resource Support, and Separation Safety). These categories reflect the full array of safety management services that should be available to support the creation of safety plans. A comprehensive array of safety management services must be available to support in-home safety management. As part of the region's implementation self-assessment and planning, each region identified the need to strengthen their safety management service array.

A significant portion of the Department's safety management service array for families under in-home protective supervision is linked to the Promoting Safe and Stable Families program, as described in the Promoting Safe and Stable Families. Availability of each type of service depends on the local CBC service structure and system of care to address community needs and population differences. This summary is arranged by the structure used in the child welfare practice model approach, discussed in Chapter IV as an ongoing intervention related to child outcomes.

Placement

The processes and choices involved in placement are crucial to ensure the Department is providing the safest and most appropriate care for children unable to live in their own homes until a permanency goal is attained. The most appropriate available out-of-home placement is chosen after assessing the child's age, sex, sibling status, special physical, educational, emotional and developmental needs, alleged type of abuse, neglect or abandonment, community ties and school placement.

Consideration for placement is chosen from least to most restrictive. Initial placement decisions for the least restrictive placements, such as relative and non-relative placements, are made by the front line staff and their supervisors. After initial emergency placement, placement services are coordinated by the Community-based Care (CBC) lead agencies. This provides an increased local community ownership of ensuring the right out-of-home care placement for children. Communities coming together on behalf of their most vulnerable children demonstrates what community-based care was designed to do: transition child welfare services to local providers under the direction of lead agencies and community alliances of stakeholders working within their community to ensure safety, well-being, and permanency for the children in their care.

In making a placement with a relative or non-relative, front line staff consider whether the caregiver would be a suitable adoptive parent if reunification is not successful and the caregiver would wish to adopt the child.

With the implementation of practice model (see discussion of this approach to practice in Chapter IV), case managers now will have responsibility for assessing when a safety plan in an in-home case is no longer sufficient to maintain the child's safety. At this juncture, the case manager and supervisors would determine the next least restrictive placement for the child, and would work with the birth family to establish conditions for return and the behavior changes needed. Out-of-home caregivers would receive this information as part of a coordinated effort by the birth family, the CBC case manager, and the out-of-home caregiver to work toward meeting the conditions for returning the child home.

Except in emergency situations or when ordered by the court, licensed out-of-home caregivers must give at least two weeks' notice prior to moving a child from one out-of-home placement to another.

During these two weeks a transition must be accomplished according to a plan that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and psychological needs, ensures the child has all of his or her belongings, allows for a gradual transition from the caregiver's home and, if possible, for continued contact with the caregiver after the child leaves.

Domestic Violence and Child Welfare Collaboration:

The Florida Coalition Against Domestic Violence (FCADV), the Domestic Violence Program Office, and the Office of Child Welfare hold quarterly meetings. These meetings serve as collaboration and integration opportunities in support of ongoing initiatives.

Historically, the Department and FCADV shared a strong working partnership aimed at integrating a seamless service delivery system when working with families experiencing domestic violence. The FCADV remains committed to assisting child welfare professionals through technical assistance, training, and legislative requests for funding opportunities that will continue to support this strong initiative for building the capacity for domestic violence advocates to be co-located within CPI and other community-based child welfare agencies. The "CPI Co-located Domestic Violence Advocate Project" was first started in 2008 with six pilot projects in Florida. The projects are a collaborative effort between FCADV, the Office of the Attorney General, the DCF, local Certified Domestic Violence Centers, Community-based Care agencies (CBCs), and criminal justice system partners that implement Leadership Teams to provide an optimal coordinated community response to families experiencing the co-occurrence of domestic violence and child abuse. FCADV's CPI Project also establishes formal partnerships in which domestic violence advocates are co-located within CPI Units.

The domestic violence co-located advocates provide consultation to child protection staff, referral services to survivors, and attend meetings between all partnering stakeholders to develop strategies to resolve any barriers or issues that may arise. The ultimate goal of these projects is to bridge the gap between child welfare and domestic violence service providers to enhance family safety, create permanency for children, and hold perpetrators accountable for their actions.

The FCADV has served on the Statewide Safety Methodology Steering Committee (now known as the Child Welfare Practice Task Force) since January, 2014 and has also been an active member of the subcommittee for policy and practice guideline development.

Substance Abuse and Mental Health Integration Information:

The Integration of Child Welfare and Behavioral Health

The Department has long acknowledged the necessity for a close relationship between the behavioral health and the child welfare systems and continues to work on methods for supporting collaboration and coordination. Substance use and mental health disorders (behavioral health) are present in at least half of the cases of child maltreatment and in a much higher percentage of the cases where children are removed from their homes. The parents in these cases must receive treatment and have an opportunity for recovery.

Children in these families are more vulnerable to instances of maltreatment, as diminished parental capacities contribute to child safety concerns. To successfully support families with mental health and substance use disorders the system must realign the current service provision model and move from a philosophy of "task-based case plan compliance" to an effective model of integrated treatment that supports behavioral change and improves parental capacity to safely care for their children. Failure to do so will continue to place children at risk of maltreatment and increased recidivism.

There are several significant, long-term initiatives that will affect the overall ability of the child welfare program to achieve the broad goal of increasing safety for children that relate to integration. These include:

- Providing training in the area of trauma-informed care for staff and caregivers, specifically as part of the pre-service curriculum and on-line training developed by the Florida Certification Board and in alignment with the child welfare practice model;
- Use of Children's Mental Health Wrap Around (100806) - The goal of these funds is to promote social and emotional well-being and resilience among children with a mental, behavioral or emotional disorder or other condition that may require clinical attention who have been removed or are at risk of removal due to abuse or neglect.
- Formation of Community Action Teams (CAT) which provide an alternative to out of home care for children with serious behavioral health disorders. The CAT model is a team based integrated service delivery approach.
- Formation of Family Intensive Treatment Teams (FIT) which are a legislatively funded pilot project for the provision of family-focused, team-based services for parents in the child welfare system with substance use disorders. The teams integrate services and treatment by providing treatment for substance use disorders, treatment for co-occurring disorders, providing parenting interventions, and through therapeutic coordination for all family members.
- Child Welfare Project Team formed with the charge to develop recommendations for improved identification of need, access to evidence-based services, coordination of care using a family-based focus, and identification of resources necessary to implement desired changes. The primary output of this team's work was the development of a Child Welfare and Behavioral Health Integration Self-Study.

The Integration of Child Welfare and Behavioral Health became one of the Department's Priority of Efforts in June 2015. The work associated with this priority has been primarily focused on the Self-Study created through the Child Welfare Project Team. The Department created Integration Process and Facilitation Guides to accompany the roll out of the Self-Study across the state. The process guide "defines", for the first time in Florida, what integration of child welfare and behavioral health is. Each Region has been tasked with the formation of local leadership teams and the completion of the Self-Study. Upon completion of the Self-Study, a Peer Review Team is assembled with representatives from different parts of the system and an on-site review is conducted. After review of the Peer Review Team report, the local leadership team decides upon a plan of action to move their system of care forward, in alignment with Florida's Model.

The Self-Study is designed to measure current practice against the Florida Model of Child Welfare and Behavioral Health Integration. The Self-Study measures practice as scored by the local teams in four

areas: Parent Screening, Referral for Behavioral Health Assessment, Family Focused Treatment, and Aligned Planning and Teamwork. Additionally, four system components are reviewed by the Region Leadership Team: Joint Accountability and Shared Outcomes, Information Sharing and Data Systems, Training and Staff Development and Budget and Program Sustainability. The considerations in the Self-Study are designed to outline the expectations as to how to achieve integration within the Child Welfare Practice Model. The Practice Model has expanded Child Welfare's focus from parental completion of case plan tasks to the measurement of behavioral change in caregiver protective capacities. With these modifications in Child Welfare practice, it has become imperative that the behavioral health organizations serving parents also modify their practices to address how behavioral health disorders are impacting parenting and to assist the parents both to move toward recovery from the behavioral health disorder and improve their parenting capacities. The communication and planning between child welfare and behavioral health organizations must adequately convey and align the details of the parent's needs and progress in recovery and improved caregiver capacity and coordinate care with treatment for the children. The Self-Study, Peer Review, and Plan of Action are part of this initiative and are intended to move each local system of care toward this model of integrated practice.

Human Trafficking Information:

On a national level, DCF has partnered with multiple states to share information developed, lessons learned, and tools developed to better identify human trafficking. We have been asked to Kansas and Kentucky to discuss our human trafficking response model. We have had phone conferences with Tennessee, Texas, North Carolina, Washington D.C, and California, to name a few, to share our Human Trafficking Screening Tool (HTST) and to discuss the evolution of our response model. DCF held an initial call with Southern Region States to include Virginia, Georgia, North and South Carolina, Mississippi, Louisiana, and Alabama to discuss their level of interest in creating a platform where states can share information, tools, policies and procedures developed to identify and responds to human trafficking. We are now in the process of identifying the platform to be utilized since the states have indicated a desire to pursue a southern regional work group. Finally, we have travelled to Minnesota and Georgia to learn about their centralized referral processes to explore their system strengths and challenges as we explore adoption of a similar structure in Florida.

Secretary Mike Carroll serves as the Vice Chair for the Florida Statewide Human Trafficking Council. In addition, the Secretary chairs the Services and Resources Committee of the Statewide Council. The Florida Attorney General leads the Council. The Council was created for the purpose of enhancing the development and coordination of state and local law enforcement and social services to combat commercial sexual exploitation as a form of human trafficking and to support victims. The Council consists of the Attorney General, Secretary of the Department of Children and Families or their designee, Secretary of Department of Juvenile Justice or their designee, the State Surgeon General or their designee, the Secretary of Health Care Administration or a designee, Executive Director of Law Enforcement or their designee, the Commissioner of Education or their designee, one member of the Senate appointed by the President of the Senate, one member of the House of Representatives appointed by the Speaker of the House of Representatives, an elected Sheriff appointed by the Attorney General, an elected state attorney appointed by the Attorney General, two members appointed by the Governor and two members appointed by the Attorney General, who have professional experience to assist the council in the development of care and treatment options for victims of human trafficking. The Council provides recommendations through an annual report to the Legislature. The Services and Resources committee of

the Statewide Human Trafficking Council is focused on the broad statewide continuum of care for youth and adult victims from prevention to placement and treatment and ending with transition and resiliency.

Statewide, the DCF statewide human trafficking prevention director maintains a close collaborative working relationship with counterparts from the Attorney General's Office, the Department of Juvenile Justice, the Department of Health and the Department of Education. Collectively these agencies are building agency strategic plans in human trafficking prevention and a coordinated statewide response. Examples of collaborative projects include: creation of a 2016 human trafficking awareness training calendar across agencies; School human trafficking awareness poster project; evaluation of human trafficking as a public health issue with the University of Miami; and participation on the Interagency Council on Human Trafficking which develops the states strategic plan on human trafficking with Florida State University.

The Department participates on human trafficking task forces across the state. Currently there are task forces operating in all 20 circuits, some county level and some are regional task forces. These task forces address local or regional needs around education and awareness, legislative response, continuum of care and response, as well as county/circuit plans to respond to cases of human trafficking. DCF has participants on all task forces and takes a leadership role in a majority of these task forces. This allows for the DCF human trafficking unit staff to have a true statewide understanding of the unique regional needs, flavor and responses, as well as recognizing gaps in continuum of care. This year we have reenergized task forces in two areas and are scheduling a training symposium in the Northwest Region, where law enforcement and state attorneys report needing training to fully understand how to identify and respond to victims of human trafficking.

DCF has utilized a collaborative approach to address several of the challenges and needs in our human trafficking identification and response mechanisms. In 2014, DCF and DJJ partnered to facilitate two statewide workgroups: one which assisted in the development of the Human Trafficking Screening Tool (HTST) and one which assisted in the drafting of a statewide assessment of Florida's system of care regarding human trafficking, titled, "Restoring Our Kids." In 2015, we partnered with Dr. Leslie Gavin, Nemours Children's Hospital, to create a level of care placement tool. In 2015, we also partnered with Dr. Patricia Babcock with the Institute of Child Welfare at Florida State University to establish trigger criteria for initiating the use of the HTST.

In 2015 and 2016, DCF spearheaded a statewide response to the clinical needs for human trafficking victims and system of care. The Department created five separate workgroups, consisting of experts across the state, to complete five specific tasks to identify:

(1) an assessment tool for adoption or creation;

(2) the array of treatment interventions the state would like to approve for victims of commercial sexual exploitation;

(3) metrics and outcomes for safe houses and safe foster homes;

(4) a curriculum for mental health professionals treating human trafficking victims; and

(5) a plan for leveraging the existing infrastructure of mental health and substance abuse providers rather than rely on the idea of building new infrastructure to treat human trafficking victims

within their communities. Workgroups have defined their deliverables and final products are due by December 2016.

In addition, the Department created a residential provider work group and host biannual meetings with providers who provide residential services to human trafficking victims. We also connect the residential providers with licensing and placement staff in regional offices and Community-based Care lead agencies. Finally, there is a recognition of the need to engage survivor leadership in the development of policies and procedures in the area of human trafficking response, as well as strategic direction of next steps. As such, a volunteer advisory group comprised of Florida survivor leadership was created to provide feedback to DCF on a variety of issues as requested. One example of an on-going conversation involves what is the role of survivor leadership in response to the human trafficking victim and what should engagement between child welfare and survivor leadership look like. From this conversation, the statewide human trafficking director and survivor leadership from The Wayne Foundation and More Too Life have drafted a training on how child welfare and survivor leadership can partner to meet the needs of the youth.

Effective July 1, 2016 the CFOP was updated, Response To The Human Trafficking of Children. This operating procedure describes the special requirements for intakes and subsequent actions relating to the commercial sexual exploitation of a child and labor trafficking of children. This operating procedure establishes the roles and responsibilities of Hotline counselors; Child Protective Investigators; contracted community-based care providers; and sub-contracted services providers in cases of human trafficking of children.

(4) Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols.

Having recently implemented a practice model, Florida continues to assess and evaluate the functionality of tools and protocols. The Department has assessed fidelity to the practice model as well as the functionality of the tools available to front line child welfare workers. The Department has contracted with outside vendors to provide technical assistance and develop capacity for learning the child welfare practice model and to assist in ensuring implementation of the practice model with fidelity.

Risk Assessment:

The practice model utilizes an actuarial risk assessment based on research as to which family characteristics have a demonstrated correlation with future abuse and neglect. The risk assessment is used at the completion of the investigation to identify the risk of subsequent harm. Children determined to be living in “high” or “very high” risk households would benefit from intervention. The investigator should make every effort to connect the family with community based family support services that are specifically planned to reduce risk of abuse or neglect. Risk levels can be very effective in helping the family understand why the investigator remains concerned about the family even though case management services are not being pursued.

(5) Developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange.

The Florida Safe Families Network (FSFN) is the state’s automated official case management record for all children and families receiving child welfare services, from screening for child abuse and neglect at the

Florida Abuse Hotline through adoption. FSFN provides opportunities to identify child welfare outcomes and practices and ensure a complete record of each child's current and historical child welfare information.

The Department continued to collaborate with all stakeholders and contracted providers. Examples of collaboration include:

- System improvements and defining build content.
- Defining and validating functional requirements and designing the system improvements.

Modernization of the Interstate Compact on the Placement of Children (ICPC)

The Interstate Compact on the Placement of Children (ICPC) is the best means we have to ensure protection and services to children who are placed across state lines. The need for a compact to regulate the interstate movement of children was recognized over 40 years ago. Since then the Department has worked with the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) to address identified areas of concern within the Interstate Compact such as the time it takes for children in the dependency system to be placed in safe homes across interstate lines.

The ICPC office collaborates in other ways with our partners, other states, and stakeholders. The use of lead ICPC liaisons within individual CBCs allows a single point of contact for both the CBC and the ICPC office, which streamlines communication and increases the efficiency of the ICPC process. The office collaborates with the regions through monthly conference calls, quarterly face-to-face meetings, through use of the ICS system, and through daily emails. Additionally, the Compact Administrator participates in the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC). The Compact Administrator attends the annual AAICPC conference and serves on various committees within the organization, allowing for the establishment and maintenance of relationships with ICPC central office staff as well as local staff from other states. The Compact Administrator also attends conferences and presents and meetings with both private and public sector partners throughout the year.

The Compact Administrator works with CLS, caseworkers, and representatives from other states on difficult cases, and often facilitates conference calls between Florida workers and other states to ensure positive outcomes for children. Further, the Florida ICPC office provides presentations as needed to the Children's Legal Services attorneys, judiciary, Guardians Ad Litem, Attorneys Ad Litem, case managers, supervisors, licensed social workers, investigators and ICPC liaisons at Community-Based Care Lead Agencies. The Compact Administrator works closely with CLS and members of the judiciary, participating in meetings and presentations throughout the year.

Modernization of the ICPC processes is an ongoing technology effort. The ICPC processing system within the State of Florida began a conversion to electronic transmittal and web based data transmission in the spring of 2008. The goal of the modernization project was to eliminate transmittal of paper ICPC files through the mail, reduce the number of persons who handle a file, and shorten the time spent in the approval process. The assignment of cases by state resulted in personal relationships being developed between Florida ICPC specialists and their counterparts in other states. Staff has also gained additional knowledge of the laws and regulations of their assigned states.

ICPC modernization converted the existing tracking system to a paperless file system. The process now scans all incoming and outgoing documents and creates various data entry screens to capture and store information on each case. One of the best features of the system is the generation of automatic e-mail reminders and notices for critical dates in the ICPC process. Additionally, the system includes a feature that allows a case specialist who is in receipt of a new case to determine if the child's records are present in FSFN and, if so, to extract the child's demographic information and import it into ICS.

The system database can be accessed by the courts, Community-Based Care lead agencies, Guardians Ad Litem, and department attorneys. These stakeholders can view the master ICPC file and determine case status. This transparency has improved the quality of ICPC work and significantly reduced the time it takes to process a case within the State of Florida.

(6) Developing, strengthening, and facilitating training.

The 2015 - 2019 Child and Family Services Staff Development and Training Plan (the Training Plan) describes Florida's three staff development and training goals listed below, along with corresponding initiatives. It was developed with careful consideration of the current state (assessment based on the data available) and visioning for where Florida will be in five years, in response to the assessment.

The initiatives were developed during in-person planning sessions with the Department's headquarters training staff, regional training staff, and community-based training partners. These planning sessions were held in March 2014 immediately following the release of the Administration for Children and Families Program Instruction regarding development of the 2015 - 2019 Child and Family Services Plan. Additional input was sought from the Seminole tribe through a telephone conversation with the tribe's family preservation administrator. The Training Plan reflects a combination of both current and new initiatives.

Organizationally, the Department's training unit is situated within the Office of Child Welfare. The unit consists of one supervisor and two specialists. The supervisor is dedicated solely to training initiatives. One specialist is dedicated to curriculum design. The other specialist is dedicated training initiatives.

Programmatically, the training unit will be responsible for ensuring that all training and staff development activities are in direct support of Florida's practice model and Florida's goals for prevention, safety, permanency, and well-being. Specifically, the training unit will ensure the following:

- The seven professional child welfare practices are effectively taught and reinforced through curricula, performance expectations, structured field experiences, coaching and supervision.
- Training curricula and field experiences are safety focused, trauma-informed, and family centered.
- Child welfare trainers have ready access to quality training materials and resources and are adequately prepared, supported, and – eventually - certified.

Administratively, the training unit will be responsible for the following:

- Tracking the training activities of the Department and community-based training providers to ensure they are supportive of the Child and Family Services Plan goals and objectives as well as the ongoing professional development of child welfare staff.

- Monitoring the expenditure of Title IV-E training dollars.
- Acting as liaison between the Office of Child Welfare and its Center for the Advancement of Child Welfare Practice (housed at the University of South Florida).

Various in-service training, work sessions, supervisory support and technical assistance needs were procured through contractual agreements with various vendors in an effort to support the continued growth and skills of Florida's child welfare professionals.

(7) Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers.

The Child Protection Summit provides support and technical assistance to those on the front end of child welfare, offering an opportunity to attend sessions designed to improve and strengthen the knowledge base and specialties of front line staff and their supervisors. In addition to the summit, the Department and Community-based Care lead agencies offer training to enhance the skill base of staff serving Florida's most vulnerable citizens.

The Child Abuse and Neglect Conference focuses on the medical aspects of child physical abuse, sexual abuse and neglect. The conference content provides an understanding of the mechanisms that inflict injury and the scientific basis for medical determinations as to whether abuse has or has not occurred.

Florida's Center for Child Welfare, "The Center," operating within the University of South Florida's College of Behavioral and Community Sciences, Department of Child and Family Studies, works in collaboration with the Department to ensure information contained on the site is timely, accurate, and useful to child welfare professionals and others. The Center is funded by the Department. Information and training resources are available 24 hours a day.

Key areas include:

- A comprehensive resource library by subject area
- A comprehensive video training library
- Frequently asked questions
- Live web events and other web conferencing services on various subjects. Interactive web events such as training, meetings, workgroup events, etc.

The Center is also home to "Just in Time Training" (part of the Quality Parenting Initiative). This service responds to requests from foster parents for training topics and provides live and recorded training for foster parents, related caregivers and child welfare professionals.

(8) Developing and facilitating research-based strategies for training individuals mandated to report child abuse or neglect.

Section 39.201(1)(a), Florida Statutes, states that "Mandatory reports of child abuse, abandonment or neglect" require that **any** person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the

child's welfare **must report such knowledge or suspicion to the Florida Abuse Hotline**. Reports may be made by one of the following methods:

- Toll-free telephone: 800-96-ABUSE
- Toll-free Telephone Device for the Deaf (TDD): 800-453-5145
- Toll-free fax transmission: 800-914-0004
- Internet at https://reportabuse.dcf.state.fl.us

Members of the general public may report anonymously, if they choose. However, reporters in specific occupation categories are **required to provide their names** to the Abuse Hotline staff. The names must be entered into the record of the report but are kept confidential as required in Section. 39.201, Florida Statutes. Everyone is considered a mandatory reporter. The following describes training on the reporting of child abuse or neglect in Florida:

- **Child Care Staff.** The Child Care Services Program Office within the Department of Children and Families is statutorily responsible for the administration of child care licensing and child care training throughout Florida. Child care personnel must begin training with 90 days of employment in the child care industry. The introductory child care training is divided into two parts: The identification and reporting of child abuse and neglect; annual in-service training requirements include child abuse, working with children with disabilities, and community, healthy and social service resources.
- **Teachers.** The Florida Department of Education (FDOE) in partnership with the Florida Department of Children and Families (DCF), and the Florida Department of Health (DOH), Children's Medical Services developed the Child Abuse Prevention Sourcebook for Florida School Personnel. The purpose of the sourcebook is to provide Florida teachers and other school district employees with information about their legal responsibilities as mandatory reporters of suspected child abuse and/or neglect, to assist them in recognizing indicators of abuse and neglect and to better prepare them to support students who have been maltreated. A one hour course is also available to educators. This course is available online and details the reporting process and outlines individual reporting requirements.
- **Public.** In the recent past curriculum was developed for a statewide public awareness campaign and educational initiative for the prevention of child abuse, through that awareness campaign there remains an active website, dontmissthesigns.org as well as related information provided through the Department's webpage, myflfamilies.com.

(9) Developing, implementing, or operating programs to assist in obtaining or coordinating necessary services for families of disabled infants with life-threatening conditions.

The Florida Interagency Coordinating Council for Infants and Toddlers (FICCIT) is authorized and required by Part C of the Individuals with Disabilities Education Act (IDEA) as amended by Public Law 105-17. The role of FICCIT is to assist public and private agencies in implementing a statewide system of coordinated, comprehensive, multidisciplinary, interagency programs providing appropriate early intervention services to infants and toddlers with disabilities and risk conditions and their families. The Department of Health is the lead agency for this council, as well, but this represents one of the more critical partnerships for young children for the Department of Children and Families.

(10) Developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect

The Florida Abuse Hotline supports each circuit with training material concerning mandated reporter information upon request.

The Florida Abuse Hotline provides on-site community support and training around the guidelines and procedures for identifying suspected child maltreatment and reporting requirements. This training is provided throughout the state. In addition, the Florida Abuse Hotline is working on facilitating "live" webinars to staff around the state. These "live" webinars allow individuals around the state to access training from their desktop computers, ask questions, and participate remotely.

The Florida Abuse Hotline also facilitates tours of the facility and allows people to listen to "live" calls to experience the process as it happens. Staff from investigations, the Guardian ad Litem, court personnel and other professionals from around the state participates in these educational tours.

(11) Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level.

Circle of Parents® is a mutual support and self-help program for parents based on a framework of shared leadership, mutual respect, shared ownership and inclusiveness. Florida Circle of Parents® provides a friendly, supportive environment led by parents and other caregivers. It's a place where anyone in a parenting role can openly discuss the successes and challenges of raising children. The groups are free, confidential and non-judgmental. Shared leadership is practiced among facilitators and parents so that participants both receive and provide help to others.

Developing leadership on the individual, family, community and societal levels, as desired by parent participants, is a central theme of the Circle of Parents® model. Meaningful parent leadership occurs when parents gain the knowledge and skills to function in leadership roles and represent a "parent voice" to help shape the direction of their families and communities and programs and policies that affect them.

Currently, throughout Florida there are 57 active Circle of Parents® groups. Efforts to continue to grow the amount and sustainability of the groups are being made on a statewide level.

(12) Supporting and enhancing collaboration among public health agencies, the child protection system, and private community-based programs to provide child abuse and neglect prevention and treatment services (including linkages with education systems) and to address the health needs, including mental health needs, of children identified as abused or neglected, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports.

The Department and its various educational partners, the Department of Education, local school boards, post-secondary institutions, foster parents and caregivers, continued to work together toward common goals for educating children, youth and young adults.

This collaboration included continuing to work on developing an infrastructure to measure the accomplishments and needs of its children in out-of-home care. The information will aid Florida's child welfare partners in creating policies and projects to further enhance children's educational success in all phases of their education, including post-secondary.

The Department participated in several workgroups and committees within the Department of Education, including the State Secondary Transition Interagency Committee for students with disabilities and the Project AWARE State Management Team for student mental health services. Additionally, the Department collaborates with the Bureau of Exceptional Education and Student Services to host quarterly conference calls with the School District Foster Care Liaisons throughout the State.

(13) Supporting and enhancing interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs.

The Office of Adoption and Child Protection

The 2007 Legislature created the Executive Office of the Governor's Office of Adoption and Child Protection (OACP) in the Governor's Office and assigned much of the same responsibilities the Task Force had undertaken in development and implementation of Florida's State Plan for the Prevention of Child Abuse, Abandonment, and Neglect: July 2005 through June 2010. In addition, the 2007 Legislature created the Florida Children and Youth Cabinet charged with developing and implementing a "shared and cohesive vision using integrated services to improve child, youth and family outcomes…"

In accordance with state law (s. 39.001, F.S), the Office of Adoption and Child Protection is steering the creation of the five-year *Florida Child Abuse Prevention and Permanency Plan: July 2015 – June 2020 (FCAPP).* The plan provides plans of action for the prevention of child abuse, abandonment and neglect; promotion of adoption; and for the support of adoptive families. This plan reflects Florida's commitment to engage state agencies and local communities in a collaborative effort to prevent child abuse, abandonment and neglect; promote adoption; and support our adoptive families.

The central focus of the *FCAPP* is to build resilience in all of Florida's families and communities in order to equip them to better care for and nurture their children. In accordance with the state law (§39.001, Florida Statutes), this five-year prevention and permanency plan provides for the prevention of child abuse, abandonment and neglect; promotion of adoption; and for the support of adoptive families. Overall, this planning effort seeks to create a statewide model for preventing abuse, abandonment and neglect; promoting adoption; and supporting adoptive families that can be embraced across branches of government, state agencies, and professional disciplines, thus providing state agency staff, state and local service providers, advocates, and the citizens of Florida with clearly articulated action steps for the realization of optimal child growth, development and well-being. A model of this nature requires a multi-pronged approach ranging from individual interventions to professional development protocols, from agency standards of practice to population-based intervention mechanisms.

(14) Developing and implementing procedures for collaboration among child protective services, domestic violence services and other agencies.

Children who are exposed to domestic violence in the home are also victims. The highest reported child maltreatment categories in Florida each year alternate between domestic violence and substance

abuse. There were reported 83,730 allegations of family violence in Florida homes during the state fiscal year (SFY) 2015-2016.

The DCF Domestic Violence Program serves as FCADV's primary partner to end domestic violence in Florida. To that end, the DCF Domestic Violence Program's primary responsibilities include oversight of funding, initial certification of newly formed domestic violence centers, and annual renewal of certifications for existing centers. As a result of the implementation of the Statewide Child Protection Investigation (CPI) Project, DCF and FCADV continue to work collaboratively to revise policy and training programs to address the complexities associated with the needs of families involved in the child welfare system that are experiencing domestic violence.

Relation of CAPTA to the Program (Quality) Improvement Plan

The five year CAPTA plan supports the activities outlined in Florida's Program Improvement Plan (PIP); the Department's Strategic Plan, and the agency's Long Range Program Plan for Fiscal Years 2017 – 2018 as well as a number of other meaningful reform efforts.

Update on the steps the state has taken since submission of the 2017 APSR and annual CAPTA report and the passage of the CARA amendments to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.

At the request of Secretary Mike Carroll, the Safety Practice Team within the Office of Child Welfare, conducted an in-depth practice review of 30 child protective investigations conducted during SFY 2015-2016 involving substance exposed newborns.

The 30 investigations were pulled randomly but with an intentional emphasis on reviewing Verified and Not Substantiated findings.

Identifying prescription drug misuse seemed particularly problematic for child protective investigators. In addition to the general challenge of adequately investigating prescription drug abuse, six additional recommendations were identified as a result of the 30 practice analysis reviews:

- The identification of danger threats by investigators in substance misuse investigations could be substantially improved by understanding the importance of assessing the totality of the known information.
- The overall assessment of child safety and safety determination in substance misuse investigations could be substantially improved by investigators obtaining additional information from substance abuse treatment personnel who have previously worked with the parent.
- Investigators need to receive additional training in identification of family dynamics commonly associated with substance misuse, specifically, co-dependency and the intergenerational cycle of abuse.
- Investigators needs additional training on how to assertively address and challenge information commonly presented by individuals misusing or addicted to drugs. The combined social stigma's of abusing a child and have a drug problem leads to a degree of secrecy, manipulation and deception rarely encountered by an investigator in the "average" investigation.

- Investigators need to expand the focus on the investigation beyond the results of the mother or infant's drug test to include significantly more information from medical staff.
- Investigators needs to expand the focus of the investigation to include other siblings of the substance exposed infant living in the household.

The multiple recommendations and issues identified in this review can be encapsulated into two major problems. First, many child protective investigators appear to lack sufficient training and knowledge regarding substance misuse in general, and more specifically, how child safety is compromised when a parent in either under the influence of a substance, or during the "rebound" period after use.

The second problem, is the failure of investigators to consistently consult with Family Intervention Specialists or other subject matter experts to inform the assessment of child safety during the investigations. While investigators often requested written treatment records on parents, investigators rarely ever documented an actual conversation with current or former substance abuse treatment personnel.

In summary of the practice analysis conducted, child protective investigators need to take into account the totality of the information known on the family related to substance misuse. Significant criminal and child welfare histories related to drug use, multiple failed treatment admissions, and documented use of prescribed or illicit narcotics or other Schedule II drugs should inform decision making and service provision to the infants and families impacted by the effects of these powerful drugs.

As a result of changes in federal legislation and the guidance learned from the review of sample cases involving substance exposed newborns, the Departments Child Maltreatment Index (CFOP 170-4) was updated on December 23, 2016 as follows:

- Added a maltreatment specific to substance-exposed newborns.
- Enhanced the definition of substance-exposed newborn to more clearly articulate when parental substance abuse poses a threat of harm to young children.
- Provided additional guidance in Factors to Consider for the maltreatment.

Florida Safe Families Network (FSFN) functionality for the additional maltreatment for substance-exposed newborn was updated to ensure alignment with the current maltreatment index.

Also updated was CFOP 170-5, Chapter 11, Substance Abuse Consultations. For the purposes of child protection assessment and interventions, it is important to accurately identify substance abuse disorders in order to determine child safety and inform parents of the comprehensive array of services available to achieve or maintain recovery. Out-of-control conditions in substance abusing families can be particularly challenging for investigators to assess because family and individual dynamics, such as denial and co-dependency issues, minimize if not outright deny that alcohol or substance misuse are problematic or are active in the family. These aspects associated with the dynamics of addiction emphasize the need for the investigator to consult with substance abuse professionals in order to assist in an accurate assessment and identification of any substance misuse or dependency problem.

The Department continues to work on the Strengthening Child Welfare Practice through Technology project, through this project and enhancements made to FSFN functionality data collection is more accurate and can be analyzed to decipher trends and numbers served.

The Department was selected to attend the 2017 Policy Academy: Improving outcomes for pregnant and postpartum women with opioid use disorders and their infants, families and caregivers.

The Department has identified a statewide leadership group to coordinate the multiple systems involved in the care of these infants and their families. Through this group ongoing policy review and revisions are occurring. At least monthly calls are occurring to discuss the steps toward the successful implementation and execution of CARA legislation.

Included on the statewide leadership group are the Department of Children and Families' Offices of Child Welfare and Substance Abuse and Mental Health, Department of Health, Agency for Health Care Administration, Healthy Families, Healthy Start, MIECHV, Florida Hospital Association, Early Steps, behavioral health care providers and associations, and the University of Florida.

As part of these group meetings, ways in which partner agencies can leverage internal policies and messaging are being maximized. The pathway and processes for notifications and response are being explored. Our statewide work will incorporate the pre-pregnancy, pre-natal, and neonatal periods and the need of the mother, infant and family.

Goals identified by the state team include:

- Develop a statewide leadership group to coordinate the multiple systems involved in the care of these infants and their families.
- Develop best practices for implementation of the CAPTA/CARA requirements to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum.
- Determine and implement best practices for the completion of the Plan of Safe Care and determine under what circumstances specific agencies would have the responsibility to develop and monitor the plan.
- Create a uniform way for active surveillance of NAS.
- Strengthen the behavioral health providers' ability to work effectively with pregnant women.
- Improve the amount and quality of screening for substance use during pregnancy.
- Increase access to contraception methods post-partum contraception, including LARC, for women with newborns diagnosed with NAS.

The Florida Abuse Hotline will remain the common intake point for notifications, a record of those notifications either "screened in" or "screened out" is available. Those notifications to the hotline which were "screened out" will be addressed through partner agencies, including but not limited to, Healthy Start, Healthy Families, MEICHV programs or through the caregivers own doctor or medical provider. Those screened in could be served through family support services or through case management.

Florida is a large and very diverse state, in order to truly understand the impact of CARA, Florida will disseminate a survey to hospital and medical staff serving families and infants affected by substance misuse. Through the survey, screening criteria of hospitals will be explored, reporting habits, and internal processes of the medical center will be reported.

The use of established prenatal screening tools for pregnant women is not consistent in Florida. Many different protocols are used by Florida's hospitals for testing newborns and identifying circumstances in which the mother may have exposed the unborn child to substances. Survey results will shed light on the practices in the pilot area as well as other areas surveyed.

Currently available is a Florida Abuse Hotline reporting mechanism through the internet. In order to better capture information needed by hotline staff and child protective investigators and to streamline reporting by hospital personnel modification of this internet reporting is underway. By modifying the reporting form information provided by medical personnel will be more thorough and include key elements which will assist hotline staff with screening decisions as well as inform the child protective investigator.

Planned for summer 2017 is a pilot project in the Tampa/Sarasota area, involving several of the hospitals in the area. Through this pilot, the Department will explore the reporting of families to the Florida Abuse Hotline, thoroughness of the information reported, timeliness of reports being made, and the impact to workload for hotline and front line child protective investigators.

Following the completion of the pilot, the Department should have an understanding of the workload impact to the Department and partner agencies. Before making statewide policies, the lessons learned and best practices will be examined to determine what has worked well and what needs modification through the pilot project. The Department and partner agencies continue to explore the best avenue for information collection around the numbers of families served through plans of safe care. While it is recognized that the number of families served through Family Support Services and Case Management will be readily available, obtaining data from those agencies outside of the purview of the Department will prove more challenging. Partner agencies are aware of the need to capture data around this population and through frequent discussion the most advantageous ways to accomplish this are being discussed and addressed.

The complexity of this issue is daunting, actions must be strategic in order to have maximum impact and address this enormous issue in a thoughtful, well planned manner. While there is a still a great deal of work to be done, Florida has navigated a large state with many moving parts to bring decision makers and front line personnel to the table with many innovative and exciting ideas. The issue of substance misuse and its impact on Florida's families is a foremost priority and it is our hope through diligent efforts to address plans of safe care that positive momentum is achieved leading to safe infants and healthy families.

The State of Florida
2016-2017 CAPTA ANNUAL DATA REPORT

1. **The number of children who were reported to the State during the year as abused or neglected.**

   SFY 2015-2016: 222,057

2. **Of the number of children described in paragraph (1), the number with respect to whom such reports were—**

   A. **Substantiated:** 42,773

   B. **unsubstantiated; or (Note: Florida's count for Unsubstantiated includes no indication findings and Not Substantiated):** 134,569

3. **determined to be false.** 298 investigations received in 2015/16 were referred to the State Attorney as potential false reports. The State Attorney makes a determination as to whether to pursue action on these, and the Department takes no further action regarding a final determination.

   Of the number of children described above (in #2) —

   A. **the number that did not receive services during the year under the State program funded under this section or an equivalent State program;** Information not available

   B. the number that received services during the year under the State program funded under this section or an equivalent State program; and

   During the State Fiscal Year (SFY) 2015-2016, there were 42,193 unduplicated victims

   C. the number that were removed from their families during the year by disposition of the case.

   During the State Fiscal Year (SYF) 2015-2016, there were 17,141 children who entered state custody.

4. **The number of families that received preventive services, including use of differential response, from the State during the year.**

   23,119 children were served.

5. The number of deaths in the State during the year resulting from child abuse or neglect.

SFY 2015-2016, 83 deaths in the State during the SFY resulting from abuse or neglect

6. Of the number of children described in paragraph (5), the number of such children who were in foster care.

1 child died while in foster care.

7.

A. **The number of child protective service personnel responsible for the—**

i. **intake of reports filed in the previous year ;**
ii. **screening of such reports;**
iii. **assessment of such reports; and**
iv. **investigation of such reports.**

2,411 investigators, as many as 205 intake counselors, and 31 intake supervisors.

B. The average caseload for the workers described in paragraph (A)

The average number of cases per Child Protective Investigator for SFY 15-16 fluctuated between 14.25 and 17.83.

8. The agency response time with respect to each such report with respect to initial investigation of reports of child abuse or neglect.

10 hours from time report received to time report commenced; *Source: 2016 NCANDS Agency File*

9. The response time with respect to the provision of services to families and children where an allegation of child abuse or neglect has been made.

10 hours from the time the Child Protective Investigator upon commencement assesses the need for services for families and children where an allegation of abuse or neglect has been made.

10. For child protective service personnel responsible for intake, screening, assessment, and investigations of child abuse and neglect reports in the State—

A. Information on the education, qualifications, and training requirements established by the State for child protective service professionals, including for entry and advancement in the profession, including advancement to supervisory positions;

B. Data of the education, qualifications, and training of such personnel;

C. Demographic information of the child protective service personnel; and

D. Information on caseload or workload requirements for such personnel, including requirements for average number and maximum number of cases per child protective service worker and supervisor.

See Attachments 2-5 to Chapter VIII.

11. The number of children reunited with their families or receiving family preservation services that, within five years, result in subsequent substantiated reports of child abuse and neglect, including the death of the child.

The number of children reunited with their families: 3,140

The number of children receiving family preservation services: 6,493

12. The number of children for whom individuals were appointed by the court to represent the best interests of such children and the average number of out of court contacts between such individuals and children.

The number of children for whom individuals were appointed by the court to represent the best interests of such children:

FFY 2015-2016: 17,808

The average number of out of court contacts between such individuals and children.

On average, volunteers see each child once a month outside of the courtroom, and many of our volunteers see their child(ren) more than once per month.

13. The annual report containing the summary of activities of the citizen review panels of the State required by subsection (c)(6).

Please refer to the Attachment section of this chapter. Attachment contains annual reports and responses from three citizens review panels.

14. The number of children under the care of the State child protection system who are transferred into the custody of the State juvenile justice system.

The number of children active as a child welfare case who were in a juvenile justice placement as of December 31, 2016 was 840. This count includes any child who had an active juvenile justice placement in a residential or detention facility, or community supervision, during the month. (Source: Regular Report 068-DJJ)

15. The number of children referred to a child protective services system under subsection (b)(2)(B)(ii)

The Department is working to align with CARA requirements, policies and practices are being modified to collect this information for future reporting.

16. The number of children determined to be eligible for referral, and the number of children referred, under subsection (b)(2)(B)(xxi), to agencies providing early intervention services under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et. seq.).

The number of children determined to be eligible: 48,194

The number of children referred in *State Fiscal Year (SFY) 2015-2016*: 31,091

ATTACHMENT 2

Child Protective Service Workforce Data

Table 1.Educational degree and experience for CBC staff

Lead CBC and Case Management Organization	Supervisors with BSW	Supervisors with MSW	Supervisors Avg Years Child Welfare experience	Case Managers with BSW	Case Managers with MSW	Case Managers Avg Years Child Welfare experience
Big Bend CBC	8	7	9.1	62	14	5.8
*Anchorage Children's Home, Inc., Children's Home Society, Inc. Emerald Coast Division, Children's Home Society North Central Division, DISC Village, Inc.						
Brevard Family Partnership						
IMPOWER	0	2	6.55	7	0	3.55
Brevard CARES	1	0	19	2	0	10
CBC Central Florida						
One Hope United						
Children's Home Society	16	3	5.28	53	13	2.5
Gulf Coast JFCS	0	0	5	5	2	4.5
Devereux	1	0	11.7	8	1	2.5
ChildNet, Inc. Circuit 15	17	5	4.3	36	9	2.3
ChildNet, Inc. Circuit 17	40	16	6.56	82	24	2.1
Children's Network Southwest Florida	0	0	9	1	0	4
Lutheran Services Florida	1	2	21.5	3	3	8
Family Preservation Services	5	2	5	33	6	3
Community Partnership for Children	1	4	9	7	2	5
Devereux CBC of Okeechobee and the Treasure Coast	1	0	3.3	2	0	2.1
*Devereux CBC and Children's Home Society of Florida						

ATTACHMENT 2

Lead CBC and Case Management Organization	Supervisors with BSW	Supervisors with MSW	Supervisors Avg Years Child Welfare experience	Case Managers with BSW	Case Managers with MSW	Case Managers Avg Years Child Welfare experience
Eckerd – Pasco Pinellas						
Youth and Family Alternatives	2	1	7	10	1	3.3
Lutheran Services FL	1	1	7.5	10	2	1.5
Directions for Living	3	1	7.1	9	1	6.6
Eckerd-Hillsborough						
Gulf Coast JFCS	1	1	8.2	14	2	3.44
Devereux	2	0	9.3	8	1	5.8
Youth and Family Alternatives, Inc.	0	0	3.5	0	0	3
FamiliesFirst Network of Lakeview*	18	2	9.9	69	1	4.7
Family Support Services of North Florida						
Neighbor to Family - Jacksonville FL	5	0	8	24	1	5
Nassau County Service Center	0	1	16	2	0	4
Jewish Family & Community Services	0	0	7.5	5	0	4.5
Children's Home Society	0	0	5	3	0	6.5
Daniel Memorial	1	1	9.4	1	1	4.25
Heartland for Children						
Gulf Coast JFCS	2	0	14	4	0	4
One Hope United - Florida Region, Inc.	2	0	8	6	1	2.5
The Children's Home Society of Florida	1	0	6.7	4	1	1.9
The Devereux Foundation, Inc.	0	0	5.6	1	0	2.2
Kids Central, Inc.						
Life Stream Behavioral Center	0	0	8.23	4	0	4.418
Youth & Family Alternatives	0	0	6	12	4	4
The Centers						

ATTACHMENT 2

Lead CBC and Case Management Organization	Supervisors with BSW	Supervisors with MSW	Supervisors Avg Years Child Welfare experience	Case Managers with BSW	Case Managers with MSW	Case Managers Avg Years Child Welfare experience
Independent Living @ Kids Central, Inc.	0	0	11	0	0	62
Kids First of Florida	0	1	7	6	0	3.5
Our Kids						
Wesley House	0	1	4.3	1	0	4.9
Center for Family and Child Enrichment, Inc.	1	1	14	11	6	5
Family Resource Center	0	2	11.09	12	3	6.19
Children's Home Society	3	2	5	2	0	2
Partnership Strong Families						
Children's Home Society of Mid Florida	0	1	6.6	0	1	1.45
Family Preservation Services of Florida, Inc.	0	0	6.2	1	1	2.5
Devereux Foundation, Inc.	0	0	6.2	1	2	2.7
CDS Family & Behavioral Health Services	0	0	24	0	0	7
Camelot Community Care, Inc.	1	1	11.2	5	2	7.11
Sarasota YMCA-Safe Children Coalition						
Youth & Family Alternatives, Inc.	1	0	7.5	5	2	3.2
Family Preservation Services	0	0	11	3	1	4
Manatee Glens Organization	0	0	5.72	5	0	2.42
St. Johns Family Integrity Program	1	1	11.5	1	2	5.0

STATE OF FLORIDA

POSITION DESCRIPTION

CAREER SERVICE ☒ **SELECTED EXEMPT SERVICE** ☐ **SENIOR MANAGEMENT SERVICE** ☐ **OTHER** ☐ _____

POSITION LOCATION INFORMATION

NAME OF AGENCY: Department of Children and Families

DIVISION/COMPARABLE: Office of the Secretary

BUREAU/COMPARABLE: Office of Deputy Secretary

SECTION/SUBSECTION: Office of Operations / Child Protection /

HEADQUARTERS/COUNTY CODE: /

INCUMBENT:

POSITION ATTRIBUTES:

EEO: 01 ☐ 02 ☒ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐

CBU: 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☒ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10 ☐

11 ☐ 18 ☐ 80 ☐ 81 ☐ 86 ☐ 87 ☐ 89 ☐ 99 ☐ Other ☐ _____

Special Risk: Yes ☐ No ☒

Overtime: Yes ☒ No ☐

CAD: Yes ☐ No ☒

Position Exempt Under 110.205(_____)(_____), F.S.
Managerial ☐ **Confidential** ☐ **Supervisory** ☐ **Other** ☐ _____

Organization Level:
Current: **Proposed:**

Position Number:	**FTE:** 1.00	**Security Role Code:** E
Current Broadband Level Code: 21-1099-03	**Current Class Title:** Child Protective Investigator	**Current Class Code:** 8371
Proposed Broadband Level Code:	**Proposed Class Title:**	**Proposed Class Code**:

Type of Transaction:

APPROVAL AUTHORITY USE ONLY

Broadband Level Code: 21-1099-03	Class Code: 8371	Approved By:	Effective Date:

APPROVED BROADBAND OCCUPATION:
Community/Social Service Spec/All Other

APPROVED CLASS TITLE:
Child Protective Investigator

1. **This position reports directly to**: Position Number _____ Broadband Level Code 21-1099-04
   Broadband Occupation Community/Social Service Spec/All Other Class Code 8372 Class Title Child Protective Investigator Supv-SES

2. **Broadband level code, class title, class code, position number, and headquarters location of each position which reports directly to this position**:

3. **What statutes establish or define the work performed**? FS Chapter 39

4. **This position has financial disclosure responsibility in accordance with Section 112.3145, F. S.**: Yes ☐ No ☒

5. Current budget for which this position is accountable (if applicable):

Salaries & Benefits	O.P.S.	Expenses
F.C.O.	Data Processing	TOTAL ALLOTMENT

If the current budget includes other areas of accountability include them in the TOTAL ALLOTMENT and provide a brief explanation.

POSITION NUMBER:

6. **Duties and Responsibilities** - Describe in detail the specific duties and responsibilities assigned to this position and the percentage of time for each. Indicate the role of this position in accomplishing the unit and agency mission. If applicable, include examples of independent, final policy decisions made and show their effect on the agency, the public, or other state agencies.

% of Time	Duties and Responsibilities
	This is professional work protecting children, working with families and conducting investigations of alleged abused, abandoned, neglected or exploited children.
	Conducts investigations regarding allegations of abuse, neglect, abandonment and/or special conditions for children;
	Collects information through interviews with the children, parents, relatives, neighbors, and other parties associated with the case;
	Engages families, identifies needs and determines the level of intervention needed to include voluntary services or court ordered dependency services; provides services linkages to agency and community resources based on needs assessment. Provides recommendations for development of case plan to Case Manager;
	Conducts initial/ongoing child Present and Impending Danger assessments;
	Develops with the family a signed Present Danger Plan and a signed safety plan for any identified threats and interventions;
	Arranges emergency placement for any child that cannot safely remain in the home;
	Notifies state attorney, law enforcement, child protection team and other required individuals as appropriate;
	Schedules and gathers information for and participates in case staffings;
	Prepares appropriate reports/documentation in coordination with Children's Legal Services and provides testimony in court;
	Maintains thorough documentation in the client records/appropriate information system(s) and maintains organized client files;
	Reports indication of abuse, neglect and/or abandonment to the Florida Abuse Hotline;
	Establishes and maintains cooperative working relationships with organizations and other agenices involved with child protective investigations such as community based providers, Children's Legal Services, law enforcement, medical personnel, schools, and other community/agency resources;
	Ensures effective communication with deaf or hard-of hearing Customers or companions in accordance with the ADA and/or Section 504 and shall manage service records and report this data and any resources and/or training needs to their designated program point of contact.

7. **Knowledge, skills and abilities, including utilization of equipment, required for the position**: Knowledge of theories and practice in child protection. Knowledge of professional ethics relating to child protection and counseling. Knowledge of family-centered interviewing and counseling techniques. Knowledge of investigative techniques. Knowledge of interviewing and observation techniques. Skill in considering child development in guiding placement of children. Ability to recognize indicators of abuse and neglect. Ability to conduct risk and safety investigations. Ability to plan, organize and coordinate work assignments. Ability to understand and apply relevant laws, rules, regulations, policies and procedures. Ability to actively listen to others. Ability to communicate effectively. Ability to maintain well-executed case files. Ability to establish and maintain effective working relationships with others. Ability to utilize computer systems. Ability to write accurate investigative reports.

8. **Licensure/registration/certification requirements** (If applicable, list the appropriate Florida Statute or federal regulation cite): Incumbents in this job class are required to use a personal vehicle to conduct field investigations, field visitations, or transportation of clients, and must maintain a valid driver's license, vehicle registration, and appropriate automobile insurance. Incumbents will receive a Vehicle Insurance Allowance. See CFOP 40-4, Vehicle Insurance Allowance For Selected Child Welfare and Adult Protective Services Staff, for additional information related to this job requirement. Florida Child Protective Investigator certification obtained within 12 months of hire.

9. **Other job-related requirements for this position**: On-Call

10. **Working hours**: (A) Daily from _____ to _____ (B) Total hours in workweek 40 (C) Explain any variation in work (split shift, rotation, etc.)

11. **Agency Use Only** –
Check those that apply: Uniform Allowance ☐ CJIP ☐ Bond Indicator ☒ Drug Screening ☒ Re-screening ☒
Security Check: No security screen required ☐ Background investigation required ☐ Background & fingerprint required ☒
Fingerprint investigation required ☐ Access to abuse records ☒ Caretaker ☒ Financial ☐ Law enforcement ☐ Management ☐
Sensitive ☐ Agency Security Check ☐ **Other:**

The following have acknowledged that the statements above, to the best of their knowledge, accurately describe the duties and responsibilities of the position.

Incumbent Signature (optional):		Date:
Discussed with Employee: Yes ☐ No ☐ Supervisor's Signature:	Title:	Date:
Approval of Reviewing Authority: (Div. Director, Agency Head or other)	Title:	Date:
Approval of Agency Personnel Officer:	Title:	Date:

Table 1.Demographic information of the child protective service personnel in CBCs

Lead CBC and Case Management Organization	Black	White	Other	Hispanic
Big Bend CBC	44%	50%	3%	3%
*Anchorage Children's Home, Inc., Children's Home Society, Inc. Emerald Coast Division, Children's Home Society North Central Division, DISC Village, Inc.				
Brevard Family Partnership				
IMPOWER	50%	41%	6%	4%
Brevard CARES	41%	41%	0%	18%
CBC Central Florida				
One Hope United				
Children's Home Society	46%	31%	4%	19%
Gulf Coast Jewish Family and Community Services	32%	19%	7%	42%
Devereux	37%	35%	2%	26%
ChildNet, Inc. Circuit 15	21%	49%	6%	24%
ChildNet, Inc. Circuit 17	21%	61%	3%	15%
Children’s Network of Southwest Florida	0%	75%	0%	25%
Lutheran Services Florida	50%	43%	0%	7%
Family Preservation Services	21%	62%	2%	15%
Community Partnership for Children	50%	43%	1%	6%
Devereux CBC of Okeechobee and the Treasure Coast	48%	39%	2%	11%

Lead CBC and Case Management Organization	Black	White	Other	Hispanic
Eckerd – Pasco Pinellas				
Youth and Family Alternatives	20%	67%	4%	9%
Lutheran Services FL	31%	60%	3%	6%
Directions for Living	24%	29%	10%	7%
Eckerd-Hillsborough				
Gulf Coast Jewish Family and Community Services	56%	29%	6%	9%
Devereux	45%	47%	0%	8%
Youth and Family Alternatives, Inc.	47%	39%	3%	11%
FamiliesFirst Network of Lakeview*	25%	68%	3%	4%
Family Support Services of North Florida				
Neighbor to Family - Jacksonville FL	44%	50%	3%	3%
Nassau County Service Center	10%	80%	10%	0%
Jewish Family & Community Services	32%	56%	3%	9%
Children's Home Society	58%	38%	0%	4%
Daniel Memorial	50%	42%	4%	4%
Heartland for Children				
Gulf Coast JFCS	49%	41%	0%	10%
One Hope United - Florida Region, Inc.	31%	63%	3%	3%
The Children's Home Society of Florida	49%	30%	6%	15%

Lead CBC and Case Management Organization	Black	White	Other	Hispanic
The Devereux Foundation, Inc.	58%	26%	0%	16%
Kids Central, Inc.				
Life Stream Behavioral Center	36%	51%	4%	9%
Youth & Family Alternatives	24%	67%	3%	6%
The Centers				
Independent Living @ Kids Central, Inc.	13%	87%	0%	0%
Kids First of Florida	37%	55%	4%	4%
Our Kids				
Wesley House	9%	68%	5%	18%
Center for Family and Child Enrichment, Inc.	87%	6%	2%	5%
Family Resource Center	65%	13%	2%	20%
Children's Home Society	54%	12%	2%	32%
Partnership Strong Families				
Children's Home Society of Mid Florida	24%	38%	0%	38%
Family Preservation Services of Florida, Inc.	42%	48%	2%	8%
Devereux Foundation, Inc.	35%	55%	0%	10%
CDS Family & Behavioral Health Services	50%	37%	0%	13%
Camelot Community Care, Inc.	29%	68%	3%	0%

Lead CBC and Case Management Organization	Black	White	Other	Hispanic
Sarasota YMCA-Safe Children Coalition				
Youth & Family Alternatives, Inc.	17%	73%	0%	10%
Family Preservation Services	6%	91%	3%	0%
Manatee Glens Organization	23%	69%	2%	6%
St. Johns Family Integrity Program	15%	81%	0%	4%

Table 2.Educational degree and experience for CPI staff

Child Protective Investigations	Supervisors with BSW	Supervisors with MSW	Supervisors Avg Years Child Welfare experience	Investigators with BSW	Investigators with MSW	Investigators Avg Years Child Welfare experience
Sheriff Pasco	2	2	10 years	5	0	2 years
Sheriff Hillsborough	1	0	13.7 years	2	1	5.1 years
Sheriff Manatee	2	0	14.4 years	2	0	3.6 years
Sheriff Broward	1	1	12 years	10	2	7 years
Sheriff Pinellas	4	2	17.35 years	3	0	9 years
Sheriff Seminole	1	0	14 years	1	1	3.31 years

Table 4.Demographic information of the child protective investigation personnel in Sheriff Offices

Child Protective Investigations	Black	White	Other	Hispanic
Sheriff Pasco	11	69	0	5
Sheriff Hillsborough	12	63	6	18
Sheriff Manatee	8	35	1	8
Sheriff Broward	76	5	5	11
Sheriff Pinellas	13	81	0	9
Sheriff Seminole	9	43	2	3

2016 ANNUAL REPORT

Florida
Faith-Based and
Community-Based
Advisory Council

400 South Monroe Street
The Capitol
Suite 2002
Tallahassee, Florida 32399
(850) 717-9261
www.flgov.com/fbcb

This annual report from the Florida Faith-Based and Community-Based Advisory Council is submitted to:

The Honorable Rick Scott, Governor, State of Florida

The Honorable Richard Corcoran, Speaker, Florida House of Representatives

The Honorable Joe Negron, President, Florida Senate

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TABLE OF CONTENTS

FLORIDA FAITH-BASED AND COMMUNITY-BASED ADVISORY COUNCIL

The Florida Faith-Based and Community-Based Advisory Council (Advisory Council or Council) was created in 2006 in Florida Statute 14.31. State leadership felt that increased involvement of faith-based and community organizations was not a sufficient substitute for necessary public funding of services to individuals, families and communities in need. Likewise, they believed that without the involvement of these groups, public expenditures alone would limit the effectiveness of these government investments. The cost effectiveness of public expenditures can be greatly improved when government is focused on results and public-private partnerships are sought as a complement in order to leverage the talent, commitment and resources of faith-based and community organizations.

During the 2010 Legislative Session, the Sunset requirement for the Advisory Council was repealed through legislation sponsored by Senator Mike Bennett and Representative Clay Ford. In addition, the Advisory Council was assigned to the Executive Office of the Governor, where it is administratively housed.

The Advisory Council shall consist of 25 members and may include, but need not be limited to, representatives from various faiths, faith-based organizations, community-based organizations, foundations, corporations, and municipalities. Members serve four year terms, except that the initial terms shall be staggered as determined by Florida Statute 14.31, appointed by and serving at the pleasure of the Governor, Senate President, and Speaker of the House.

The Advisory Council shall meet at least once per quarter per calendar year whether in-person, via teleconference, or through other electronic means. Annually, the Advisory Council shall elect from its membership one member to serve as Chairman of the Advisory Council and one member to serve as Vice Chairman. The mission statement was created and approved by the Advisory Council on June 11, 2013. The vision statement was approved by the members on April 8, 2014.

Mission Statement

The Florida Faith-Based and Community-Based Advisory Council exists to facilitate connections to strengthen communities and families in the state of Florida.

Statutory Charge

To advise the Governor and the Legislature on policies, priorities and objectives for the state's comprehensive efforts to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community organizations to the full extent permitted by law.

Vision

To maximize the collaboration between faith-based and community organizations and State agencies to help strengthen individuals and families.

Administrative Support

On June 12, 2007, the bill creating the Governor's Office of Adoption and Child Protection (Office) was signed into law. The duties and responsibilities of the Office are enshrined in Florida Statute 39.001. The Office was created for the purpose of establishing, implementing, and monitoring a comprehensive, cross-agency approach for the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment and neglect across the state. In October 2011, the Executive Office of the Governor allocated responsibility for administrative functions and support for the Advisory Council to the Governor's Office of Adoption and Child Protection.

The Office worked diligently throughout 2016 to advance the efforts of the Advisory Council. As of April 2015, the Office personnel, including one full-time employee, Zackary Gibson (Chief Child Advocate and Director) and one part-time employee, Frenchie Yon (Program Support), have provided support through a servant leadership approach. In addition, the Office utilized student interns to assist with many tasks supporting the Advisory Council. The Office facilitated and coordinated meetings, travel logistics, meals, overnight accommodations, ground transportation, and site visits to local community organizations. Additionally, the Office developed correspondence, drafted meeting agendas, invited presenters to speak, worked with the Governor's, Senate President's and Speaker of the House's Appointments Office; and assisted in the creation of this annual report.

Website

The Advisory Council website can be found at: *www.flgov.com/fbcb*, and can also be found by visiting the Office's main page at *www.flgov.com/child_advocacy*. All Advisory Council meetings, as well as Advisory Council Workgroup meetings, are listed on the Office's Meeting Advisory webpage: *www.flgov.com/child_advocacy_meetings*.

ADVISORY COUNCIL MEMBERS

As of December 2016, there were 20 members appointed to the Advisory Council. The following identifies each member, the organization they represent, the appointment authority, the workgroups they serve on, and topics they can assist others with.

Patricia "Pat" Smith
Chairman
Department of Children and Families
Governor's Appointee

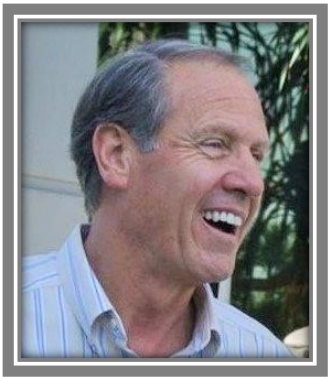
Serves on the following workgroups: Annual Conference (Chair) and Family Initiatives

Can assist others with: Adoption, Child Abuse Prevention, Leadership Strategy, Mentoring Young Adults, Prevention/Diversion, and Single Mothers

Richard Albertson
Vice Chairman
Live the Life Ministries
Governor's Appointee

Serves on the following workgroups: Family Initiatives (Chair) and Annual Conference

Can assist others with: Corrections/DJJ Re-entry, Fatherhood, Leadership Strategy, Legislative/Policy, Marriage Education, Mentoring, Relationship Education, Sexual Risk Avoidance for Youth, and Youth in DJJ Program



Pastor Kirt Anderson
Naples Community Church
Governor's Appointee

Serves on the following workgroups: Legislative

Can assist others with: Educational Tutoring, Fatherhood, Food Services, Homelessness, Human Trafficking, Jail Ministry, Leadership Strategy, Legislative/Policy, Marriage Education, Mentoring, and Substance Abuse

Rabbi Sholom Ciment
Chabad Lubavitch of Greater Boynton Beach
Governor's Appointee

Serves on the following workgroup: Disaster Planning

Can assist others with: Adoption, Child Abuse Prevention, Disaster Relief, Domestic Violence, Educational Tutoring, Elderly Populations, Family Preservation, Leadership Strategy, Legislative/Policy, Mental Health, Mentoring, Military/Veterans, Persons with Disabilities, Single Mothers, and Workforce/Employment

Trenia Cox
Juvenile Welfare Board of Pinellas County
Governor Appointee

Serves on the following workgroup: Annual Conference and Child Welfare

Can assist others with: Child Abuse Prevention, Corrections/DJJ Re-entry, Disaster Relief, Domestic Violence, Educational Tutoring, Family Preservation, Food Services, Homelessness, Human Trafficking, Jail Ministry, Kinship Care, Leadership Strategy, Legislative/Policy, Mental Health, Mentoring, Military/Veterans, Single Mothers, Substance Abuse, Workforce/Employment, and Youth in DJJ Programs

Reverend James "Perry" Davis
Christ to Inmates, Inc.
Speaker of the House Appointee

Serves on the following workgroup: Criminal Justice

Can assist others with: Corrections/DJJ Re-entry, Fatherhood, Jail Ministry, and Substance Abuse

Alan C. Dimmitt, MPA
Liberty Youth Ranch
Governor's Appointee

Serves on the following workgroups: Child Welfare

Can assist others with: Adoption, Child Abuse Prevention, Foster Care/Aging Out, Kinship Care, Mentoring, Homelessness, and Legislative/Policy

Sheila Gomez
Catholic Charities of Palm Beach County
Governor's Appointee

Serves on the following workgroups: Disaster Planning (Chair)

Can assist others with: Child Abuse Prevention, Counseling Services, Elder Affairs, Guardianship, Hunger, Homelessness, Immigration Legal Services, Health and Wellness, Human Trafficking, Prison Ministry, Refugee Services, and Transitional Housing

Roland "Roly" Gonzalez
Victory for Youth
Governor's Appointee

Serves on the following workgroup: Child Welfare (Chair) and Annual Conference

Can assist others with: Adoption, Child Abuse Prevention, Food Services, Foster Care, Disaster Preparedness and Response, Domestic Violence, Human Trafficking

Dr. Jerry Haag, CFP
Florida Baptist Children's Home
Governor's Appointee

Serves on the following workgroups: Child Welfare, Annual Conference and Legislative

Can assist others with: Adoption, Child Abuse Prevention, Domestic Violence, Foster Care/Aging Out, Human Trafficking, Independent Living, Mental Health, Mentoring, Prevention/Diversion, and Single Mothers

Dr. Gretchen Kerr
Northland, A Church Distributed
Governor's Appointee

Serves on the following workgroups: Criminal Justice (Chair)

Can assist others with: Corrections/DJJ Re-Entry, Disaster Relief, Homelessness, Human Trafficking, Mentoring, and Substance Abuse

Thomas "Tom" Lukasik
4KIDS of South Florida
Governor's Appointee

Serves on the following workgroups: Family Initiatives

Can assist others with: Adoption, Child Abuse Prevention, Foster Care/Aging Out, Independent Living, and Prevention/Diversion

Dr. Leonel "Leo" Mesa, LMHC
New Day Center
Governor's Appointee

Serves on the following workgroups: Annual Conference and Child Welfare

Can assist others with: Child Abuse Prevention, Domestic Violence, Elderly Populations, Family Preservation, Fatherhood, Health Initiatives, Kinship Care, Marriage Education, Mental Health, Persons with Disabilities, Relationship Education, and Substance Abuse

Pastor Pam Olsen
International House of Prayer
Governor's Appointee

Serves on the following workgroups: Legislative (Chair)

Can assist others with: Adoption, Human Trafficking, Legislative/Policy

Pastor Carl E. Reeves
Greater Mount Lily Baptist Church
Governor's Appointee

Serves on the following workgroups: Annual Conference and Criminal Justice

Can assist others with: Corrections/ DJJ Re-entry, Family Preservation, Homelessness, Leadership Strategy

Patricia Robbins Alger
Farm Share
Governor's Appointee

Serves on the following workgroups: Disaster Planning and Family Initiatives

Can assist others with: Disaster Relief, Food Services, and Legislative/Policy

Marcus Smith
Department of Juvenile Justice
Governor's Appointee

Serves on the following workgroups: Annual Conference, Criminal Justice, and Legislative

Can assist others with: Corrections/DJJ Re-entry, Human Trafficking, Legislative/Policy, Mentoring, Prevention/Diversion, Youth in DJJ Programs

Blaine Whitt
Xtreme Soulutions
Speaker of the House Appointee

Serves on the following workgroup: Criminal Justice

Can assist others with: Corrections/DJJ Re-Entry and Prison Ministry

Karim Veerjee
Florida Hospital
Governor's Appointee

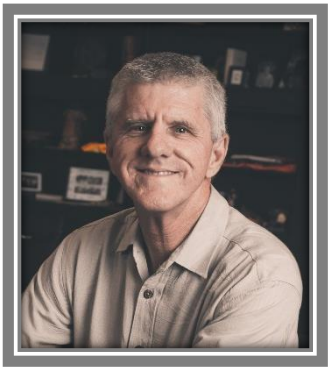
Serves on the following workgroup: Annual Conference and Disaster Planning

Can assist others with: Disaster Relief, Health Initiatives, Human Trafficking, and Mental Health

Pastor Reno Zunz
Idlewild Baptist Church
Speaker of the House Appointee

Serves on the following workgroup: Family Initiatives

Can assist others with: Adoption, Fatherhood, Leadership Strategy, and Marriage Education



The diversity of topics where information and support can be provided offers unique opportunities to facilitate connections between state and local groups to improve outcomes. Through individual and workgroup approaches, the Advisory Council builds relationships with stakeholders to advocate and advance prevention and promotion efforts that can result in more effective public-private partnerships and cost savings to the state.

2016 Advisory Council Appointments

The following member was appointed or re-appointed during 2016 with their date of appointment:

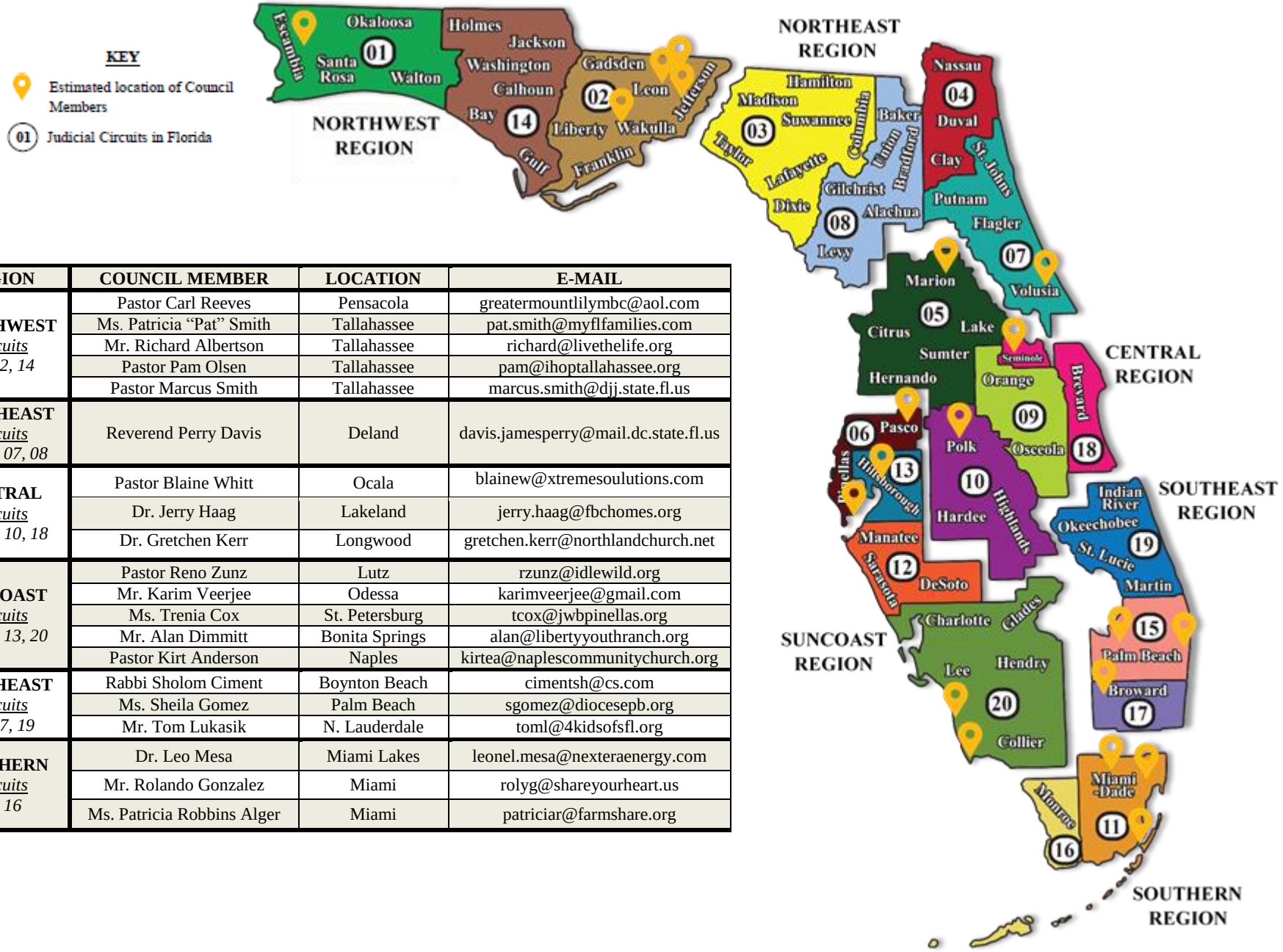
- Pastor Kirt Anderson – Reappointed – January 29, 2016
- Trenia Cox – Appointed – January 29, 2016
- Sheila Gomez – Appointed – January 29, 2016
- Roland Gonzalez – Re-appointed – January 29, 2016
- Pastor Carl Reeves – Reappointed – January 29, 2016

We would like to express our thanks and appreciation to the following individuals for their service on the Advisory Council and wish them the very best in their future endeavors:

- Stephen "Spike" Hogan – Term ending July 2015
- Carolyn Ketchel – Term ending July 2016
- Rabbi Jeffrey Kurtz-Lendner – Term ending July 2016

2016 Advisory Council Map

The Advisory Council Map, located on the next page, provides a strategic layout to identify where Advisory Council members are located throughout the state. Advisory Council members serve as regional points of contact for local faith-based, volunteer and community organizations to assist in facilitating connections with state agencies and partners to improve outcomes for children and families. This map is divided into six (6) regional boundaries and identifies Florida's 20 judicial circuits. As a quick reference, this map demonstrates the diverse geographical representation by members of the Advisory Council where they can work with and assist local faith-based and community-based groups.

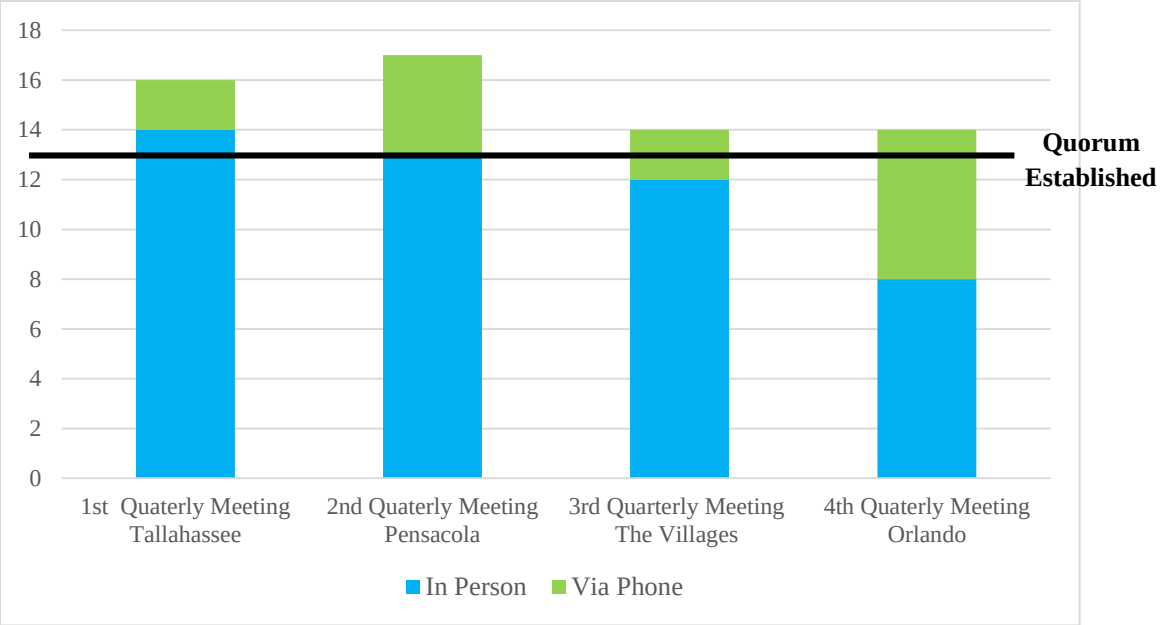


REGION	COUNCIL MEMBER	LOCATION	E-MAIL
NORTHWEST *Circuits* *01, 02, 14*	Pastor Carl Reeves	Pensacola	greatermountlilymbc@aol.com
	Ms. Patricia "Pat" Smith	Tallahassee	pat.smith@myflfamilies.com
	Mr. Richard Albertson	Tallahassee	richard@livethelife.org
	Pastor Pam Olsen	Tallahassee	pam@ihoptallahassee.org
	Pastor Marcus Smith	Tallahassee	marcus.smith@djj.state.fl.us
NORTHEAST *Circuits* *03, 04, 07, 08*	Reverend Perry Davis	Deland	davis.jamesperry@mail.dc.state.fl.us
CENTRAL *Circuits* *05, 09, 10, 18*	Pastor Blaine Whitt	Ocala	blainew@xtremesoulutions.com
	Dr. Jerry Haag	Lakeland	jerry.haag@fbchomes.org
	Dr. Gretchen Kerr	Longwood	gretchen.kerr@northlandchurch.net
SUNCOAST *Circuits* *06, 12, 13, 20*	Pastor Reno Zunz	Lutz	rzunz@idlewild.org
	Mr. Karim Veerjee	Odessa	karimveerjee@gmail.com
	Ms. Trenia Cox	St. Petersburg	tcox@jwbpinellas.org
	Mr. Alan Dimmitt	Bonita Springs	alan@libertyyouthranch.org
	Pastor Kirt Anderson	Naples	kirtea@naplescommunitychurch.org
SOUTHEAST *Circuits* *15, 17, 19*	Rabbi Sholom Ciment	Boynton Beach	cimentsh@cs.com
	Ms. Sheila Gomez	Palm Beach	sgomez@diocesepb.org
	Mr. Tom Lukasik	N. Lauderdale	toml@4kidsofsfl.org
SOUTHERN *Circuits* *11, 16*	Dr. Leo Mesa	Miami Lakes	leonel.mesa@nexteraenergy.com
	Mr. Rolando Gonzalez	Miami	rolyg@shareyourheart.us
	Ms. Patricia Robbins Alger	Miami	patriciar@farmshare.org

ADVISORY COUNCIL MEETINGS

Meeting Attendance

As identified in Florida Statute 14.31, a total of 13 members must be in attendance in order to establish a quorum for the purpose of voting on Advisory Council action and activities. Members may participate in scheduled meetings across the state either in-person or via teleconference call. The chart below reflects attendance for each Advisory Council meeting during 2016.



Meeting materials and summaries of each meeting were developed and are posted on the Advisory Council's website at: *http://www.flgov.com/fbcb-meetings-2016*.

Meeting Outreach

The Florida Channel live streamed and recorded three meetings of the Advisory Council and the Florida Faith Symposium. This assisted in reaching organizations and individuals throughout the state to increase awareness of the Advisory Council's purpose and mission, upcoming events, and various initiatives to improve outcomes for Floridians.

The Advisory Council allocated time before, during and after two Council meetings to create opportunities for meeting participants to become aware of and connect with local and state organizations. This resulted in the development of partnerships to expand services and work to improve outcomes for targeted populations. The Advisory Council also participated on site visits during two meetings to increase awareness of services being offered through faith and community-based organizations. Information on the site visits are included in the meeting highlights on the following pages.

Tallahassee, Florida
FIRST QUARTERLY MEETING

First Quarterly Meeting Highlights

The first quarterly meeting of 2016 took place on January 26th at Florida Capitol in Tallahassee, FL. Chair Pat Smith welcomed the Advisory Council and attendees. The opening prayer was given by Reverend Dr. R. B. Holmes, Jr., Senior Pastor of Bethel Missionary Baptist Church in Tallahassee, FL.

- Recognition of the 2016 Council Leadership: Ms. Pat Smith as Chair and Mr. Richard Albertson as Vice-Chair
- State Agency leadership were invited to share their initiatives to engage faith and community-based organizations to enable the Council to target their efforts throughout the year. State agencies represented include:
  - Agency for Persons with Disabilities
  - Department of Agriculture and Consumer Services
  - Department of Children and Families
  - Department of Corrections
  - Department of Education
  - Department of Elder Affairs
  - Department of Health
  - Department of Juvenile Justice
  - Division of Emergency Management
- The Advisory Council also heard from special guests on their perspectives to engage faith and community-based organizations to partner with state government.
  - The Honorable Eleanor Sobel, Florida Senator and Chair of the Children, Families, and Elder Affairs Committee
  - The Honorable Gayle B. Harrell, Florida House Representative and Chair of the Children, Families and Seniors Subcommittee
  - The Honorable, Dennis Baxley, Florida House Representative and Chair of the Local and Federal Affairs Committee
- Presentations were made by:
  - Reverend Dr. Russell Meyer, Executive Director, Florida Council of Churches, presented an overview of the Florida Council of Churches.
  - Mr. Jabari Paul presented on the Faith in Florida organization.
  - Reverend Anthony Evans presented on the National Black Church Initiative.
  - Mr. Charles McDonald, Executive Director of Children's Home Society, and Mrs. Missy Albritton, presented information on the 111 Project and efforts to bring the project to Tallahassee.
- Public Comments included:
  - Pastor Gary Montgomery shared information on the Children of Inmates program.

Second Quarterly Meeting Highlights

Brownsville Assembly of God

The second quarterly meeting took place on April 26th at Brownsville Assembly of God. Prior to the meeting, the Advisory Council toured the medical/dental clinic for low-income residents and Charis House operated by Mt. Olive Baptist Church. Charis House is a ministry for women struggling with addition and provides a home-like setting for their drug and alcohol recovery program. On the day of the meeting, 28 exhibitors were present to engage and connect with attendees.

charis house

The Reverend Dr. Earl F. Jackson, Pastor with the Damascus Road Missionary Baptist Church in Pensacola provided the opening prayer and Commissioner Lumon May, Escambia Board of County Commissioners, District 3, provided the welcome to members and attendees.

- Ms. Trenia Cox and Ms. Sheila Gomez were both introduced and welcomed as new members to the Advisory Council.
- Information on upcoming awareness month topics and events were presented.
- Presentations were made by:
  - Dr. Evon Horton, Senior Pastor of Brownsville Assembly of God, presented on the Brownsville initiative, which partners elected local officials with faith-based organizations to provide resources for the betterment of the community.
  - Pensacola Police Chief David Alexander III presented information on the Safe Heaven Initiative which focused on bridging the division between youth and society through faith and relationships.

PENSACOLA POLICE COURTESY • INTEGRITY • PROFESSIONALISM

FamiliesFirst Network of Lakeview

BAPTIST HEALTH CARE

  - Mr. Shawn Salamida, CEO of Families First Network, presented on the organization's initiatives and marketing strategies to promote adoption of children in foster care.
  - Superintendent Mary Beth Jackson and her team with the Okaloosa County School District and the Honorable Terrance Ketchel, Circuit Judge, First Judicial Circuit, presented on collaborative efforts of the district, courts and sheriff's office to address truancy from school.

OCSD Okaloosa County School District

First Judicial Circuit of Florida

  - Mr. Justin Mandrup-Poulsen, GIS Technician with the Department of Agriculture and Consumer Services, presented the *Road Map to Healthy Living* website and demonstrated features on this tool that can identify areas in need of healthy foods during the summer months.
- Advisory Council members shared activities that support the mission of the Council to faciltate connections to strengthen communities and families.

Special thanks to (left to right) Pastor Carl Reeves, Ms. Carolyn Ketchel and Ms. Phyllis Gonzalez with DCF for their efforts to coordinate the meeting, presenters and exhibitors; and Ms. Patricia Robbins and Farm Share for providing breakfast items.




FARM SHARE FEEDING FAMILIES www.farmshare.org

Pensacola, Florida
SECOND QUARTERLY MEETING

The Villages, Florida
THIRD QUARTERLY MEETING

Third Quarterly Meeting Highlights

The third quarterly meeting took place on July 26th in The Villages, Florida at the Rohan Regional Recreation Center. Prior to the meeting, the Advisory Council toured the Marion County Correctional Institution and learned about services offered through the Xtreme Soulutions program to build faith and character behind the razor wire. On the day of the meeting, 17 exhibitors were present to engage and connect with attendees.

The Honorable Dennis Baxley, Florida House Representative, provided the opening prayer and the Honorable Marlene O'Toole, Florida House Representative, provided the welcome to the members and attendees.

- Updates were provided from each of the Advisory Council's workgroups, as well as awareness month topics and events that corresponded with each workgroup.
- Presentations were made by:
  - Mr. John Cooper, CEO of Kids Central Inc., presented information on initiatives and strategies to recruit foster and adoptive families.
  - Ms. Susan Cizmadia, Administrator, Circuit 5 Community Corrections, spoke on behalf of Mr. Dann Eberlein, State Community Transition Administrator, on how the Department created the Division of Development, Improvement, and Readiness to provide services and resources to institutions and community corrections. She also shared information on the types of community supervision provided by Community Corrections.
  - Ms. Nicki Brown, State Bonding Coordinator with the Department of Economic Opportunity, presented opportunities through the Federal Bonding Program.
  - Ms. Debra Wise-Velez with Kids Central Inc., Mr. Gene Barton with Helping Hands Outreach Ministries, and Mr. Gary Cantrell with New Covenant UMC, presented information on their partnership serve and strengthen families in the Wildwood community.
- Public Comments included the following:
  - Ms. Shay Rayzar shared information about her work in Lake County with homeless and youth aging out, and asked faith leaders for their assistance and resources.
  - Ms. Erin Hess shared how faith organizations can promote health with congregations.
  - Mr. Howard Moon spoke about the Born Drug Free Line and CLEAR Warm Line and how they serve to assist those in need.

Special thanks to (left to right) Pastor Blaine Whitt, Ms. Joelle Aboytes and Mr. Jeremy Thomas with DCF for their efforts to coordinate the meeting, presenters and exhibitors; Ms. Patricia Robbins-Alger and Farm Share for providing breakfast items, and the Sumter County Children's Alliance for providing lunch items.




Fourth Quarterly Meeting Highlights

The fourth quarterly meeting took place on November 1st at the Wyndham Orlando Resort International Drive in conjunction with the Florida Faith Symposium. Chair Smith welcomed members and attendees. Member Karim Verjee provided the opening prayer.

The focus of the meeting was to review Advisory Council workgroups, accomplishments and plan for 2017. The Lead member of each workgroup provided an overview of initiatives and progress made throughout the year. This also included a review of each workgroup narrative descriptions and membership to advance the Council's mission. The following workgroups were discussed:

1. Annual Conference Workgroup
   - *Lead* – Chair Pat Smith
2. Child Welfare Workgroup
   - *Lead* – Mr. Roland Gonzalez
3. Criminal Justice Workgroup
   - *Lead* – Dr. Gretchen Kerr
4. Disaster Planning Workgroup
   - *Lead* – Ms. Sheila Gomez
5. Family Initiatives Workgroup
   - *Lead* – Vice-Chair Richard Albertson
6. Legislative Workgroup
   - *Lead* – Pastor Pam Olsen

The Council discussed various locations to host quarterly meetings in 2017. Members also discussed and supported opportunities to conduct workgroup meetings in advance of scheduled business meetings. The following venues were selected:

- Ft. Lauderdale.
- Orlando (Outside of the Faith Symposium)
- St. Petersburg
- Tallahassee

The Chair opened the floor to accept volunteers and nominations for the 2017 Vice-Chair position. The following list identifies the nominees.

- Dr. Gretchen Kerr volunteered to serve as Vice-Chair.
- Chair Pat Smith nominated Pastor Marcus Smith to serve as Vice-Chair and Pastor Marcus Smith Accepted.
- Pastor Marcus Smith nominated Pastor Carl Reeves to serve as Vice-Chair.

Due to time constraints, a final vote will take place via email for members to cast their vote.

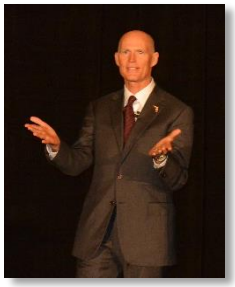
ADVISORY COUNCIL INITIATIVES

Each workgroup of the Advisory Council is designed to align and support state agency initiatives and works to facilitate connections with faith, volunteer and community-based organizations to improve collaboration and coordination of efforts. The information below highlights activities of each workgroup. The Advisory Council participates on Florida's Five-Year Child Abuse Prevention and Permanency Plan and serves as a Citizen's Review Panel for DCF. Each Advisory Council member serves on at least one workgroup.

Annual Conference Workgroup

Secretary Mike Carroll

The Advisory Council was part of one of the largest gathering of faith-based organizations and government agencies in the state of Florida. In collaboration with DCF and the Department of Juvenile Justice (DJJ), the 2016 Florida Faith Symposium in Orlando featured another round of inspirational speakers and dynamic musical performers. The Very Reverend Paul J. Henry, Rector of Mary, Queen of the Universe, in Orlando, opened the symposium with the invocation and Secretary Mike Carroll with DCF and Deputy Secretary Tim Niermann with DJJ provided opening remarks. The symposium was once again honored to have Governor Rick Scott attend to share his faith and desire to make Florida the best state in the nation.


Governor Rick Scott


Pastor Paula White-Cain

Pastor Paula White-Cain, Senior Pastor of New Destiney Christian Center in Apopka, FL, provided an interactive and inspirational keynote message. Musical performer, Christopher Duffley, with his sister Grace, sang, "Open the Eyes to My Heart", and shared his personal story of overcoming medical challenges, being adopted, and serving to be an inspiration to others through his music and podcasts. Attendees broke from the morning session to attend one of the 36 workshops offered at the two-day symposium.


Grace and Christopher Duffley


Ernie Sims and Jonathan Evans

During the luncheon, Heather Cox-Rosenberg, DCF Children's Ombudsman, provided the invocation and recording artist Omega Forbes got the audience moving in preparation for the Champion of Hope award nominees and winners for DCF and DJJ (*see Champion of Hope Awards section).* Mr. Jonathan Evans, the Dallas Cowboys' Chaplain, provided a powerful luncheon keynote address that focused on how we are all interconnected and can play a role to help others.

Division Director Shannon Hughes

Mr. Jack Levine, Founder of 4Generations Institute, opened the second day of the symposium by providing the invocation. Ms. Shannon Hughes, Division Director for the Division of Community Health Promotion with the Department of Health (DOH), and Ms. Penny Jones, Director of Corporate Relation & Partnerships with Florida Hospital, providing opening remarks. The symposium hosted an amazing Youth Panel Discussion, moderated by Ms. Tanya Wilkins, which featured youth involved in state systems, who shared their experiences in the system and how they are working to create a positive future.


Tanya Wilkins (center) with Youth Panelist

Pastor Marcus Smith

Recording artist Omega Forbes ignited the audience with his powerful voice and member Marcus Smith provided the invocation. The Champions of Hope nominees and winner for DOH were announced. The Reverend Dr. R.B. Holmes took the stage to deliver a crowd-raising address that emphasized the importance of serving children and families. Ms. Alice Sims, Assistant Secretary of Prevention and Victim Services, provided final remarks to before attendees broke to attend the final workshops offered.


Omega Forbes

A special thank you is expressed to everyone for their participation in the 2016 Florida Faith Symposium. With over 500 attendees and 41 exhibitors, the symposium continues grow and build momentum to facilitate connections between government and faith and community-based organizations to improve services for Floridians. Specifically, we would like to recognize Chair Pat Smith for her leadership on the Annual Conference Workgroup and for the amazing job serving as Mistress of Ceremonies. We would also like to recognize the Symposium Planning Team for their efforts to coordinate all aspects of the symposium.

The Very Rev. Paul J. Henry

Deputy Secretary Tim Niermann


Chair Pat Smith

Penny Jones

Jack Levine


Rev. Dr. R.B. Holmes

Champion of Hope Awards

Realizing the value of faith communities and organizations in providing support to the state and state agencies, the Champions of Hope award was created to recognize organizations that go above and beyond the ordinary to improve the lives of at-risk youth and children in care. The Annual Conference Workgroup provided nomination forms to the Department of Children and Families, Department of Juvenile Justice and Department of Health for dissemination to regional offices to identify and nominate faith-based organizations for consideration. There were a total of 18 nominees to include:

- Black on Black Crime Taskforce and Mentor2Mentor, Gainesville, FL
- Mt. Zion A.M.E. Church, Miami Gardens, FL
- Mr. Will Halvosa, Gainesville, FL
- Bethel Missionary Baptist Church, Tallahassee, FL
- Christ Fellowship, Miami, FL
- Christian Heritage Church, Tallahassee, FL
- Foundation for Foster Children, Winter Park, FL
- Grace Way Church, Leesburg, FL
- Helping Hands Ministry, The Villages, FL
- Wishing and Fishing Reach and Teach Ministry, Inc., Clearwater, FL
- Allen Temple AME Church, Tampa, FL
- Hope Kids Community, Bradenton, FL
- Mayflower Congregational, Naples, FL
- Pine Manor Improvement Association, Ft. Myers, FL
- Running Zone Foundation, Melbourne, FL
- St. Martin de Porres Community Outreach Ministry, Palm Beach, FL
- Shepherd's Hands of Suwannee Valley, Inc., Live Oak, FL
- Titus 2 Partnership, Inc., Panama City, FL

The 2016 winners are listed below by the presenting state agency:

Department of Juvenile Justice – Black on Black Crime Taskforce and Mentor2Mentor

Department of Children and Families – Bethel Missionary Baptist Church

Department of Health - Shepherd's Hands of Suwannee Valley Inc.

Child Welfare Workgroup

Led by Mr. Roland Gonzalez, the Child Welfare Workgroup assisted to advance efforts to enhance and improve the welfare of children in Florida. The workgroup focused on increasing awareness of topics to include prevention of child maltreatment, foster care, adoption, independent living, human trafficking, health and well-being, youth with disabilities, and education. The workgroup coordinates efforts with state agency liaisons and various faith-based and community-based organizations to identify needs, gaps in services, and propose solutions in order to facilitate a more collaborative and coordinated approach to improving outcomes for children and families.

Progress made throughout 2016 includes:

- Increasing awareness of healthy child development and participating in the Pinwheels for Prevention Campaign.
- During three Council meetings, chief executive officers from CBC Lead Agencies presented information and strategies to recuit foster and adoptive parents.
- Through the support of the Legislature, the Share Your Heart program received funding to serve families and individuals in crisis or distress by providing food, clothing, emotional and spiritual support through a volunteer chaplaincy network.
- Promoted and shared information on state agency initiatives and awareness month topics to support healthy child and family development.

SHARE YOUR
www.shareyourheart.us

Areas of focus for 2017 include:

- Identify opportunities to develop a volunteer chaplaincy network to expand the Share Your Heart program to other areas of the state.
- To continue engaging faith and community-based organizations to participate in the Pinwheels for Prevention campaign and to assist in promoting foster care and adoption.
- To provide information and training to faith-based organizations, who provide child care services, on child development and how to speak with families regarding concerns and available resources.

Criminal Justice Workgroup

Led by Dr. Gretchen Kerr, the Criminal Justice Workgroup supported efforts of the Department of Corrections and DJJ to improve outcomes for their populations. The workgroup focused on identification of best practices and effective strategies to include prevention, early intervention, diversion and re-entry or reintegration of adults and juveniles from jail and juvenile facilitaties, substance abuse, mental health, and persons with disabilities. The workgroup will bring together state agency liasions and vairous faith-based and community-bsaed organizations to identify needs, gaps in services, and propose solutions in order to fcilitate a more collaborative and coordinated approach to working with state government agencies.

Progress made throughout 2016 includes:

- Initiated communication with FDC around re-entry efforts to identify how faith-based organizations can better support inmates through programs and services.
- Highlighted information on the Federal Bonding Program that provides fidelity bonds to encourage employers to consider hiring individuals that may have a questionable background.

- Conducted presentations on how faith and government can work together and coordinate efforts to serve individuals and families in need.
- Supported the state's efforts to raise awareness of human trafficking prevention and promoted participation in the Human Trafficking Summit led by Attorney General Pam Bondi. Northland church partnered with Shared Hope International to host the Just Faith Summit to engage faith organizations on their efforts to combat human trafficking.
- Promoted and shared information on state agency initiatives and awareness month topics to support healthy child and family development.

Areas of focus for 2017 include:

- Continue to build relationships with FDC and DJJ to support prevention, diversion and re-entry initiatives.
- Promote the Childrens of Inmates program that can strengthen relationships between children and their incarcerated parent.
- To explore hosting a faith and government event to highight collaboration and efforts to address human trafficking.
- To continue identifying opportunities to promote the work of the Advisory Council and associated workgroups, and to facilitate connections for organizations who wish to be involved.

Disaster Planning Workgroup

Led by Ms. Sheila Gomez, the Disaster Planning Workgroup assisted to further engage faith and community-based organizations in the state's efforts to effectively prepare, respond, and recover from natural and man-made disasters. The workgroup assisted in facilitating connections of organizations and groups to existing state/regional/lcocal teams and networks to enable communities to come together before and after a disasters.

Progress made throughout 2016 includes:

- Disseminated information on hurricane preparedness activities.
- Encouraged contributions to the Florida Disaster Fund after the Pulse nightclub shooting.
- Supported DOH's efforts to raise awareness of the Zika virus and the *Spill the Water* campaign.
- Engaged the Division of Emergency Management to provide informational cards on preparedness activities to be included in all conference bags at the Florida Faith Symposium.

Areas of focus for 2017 include:

- Support the state's efforts to encourage preparedness for mosquito and hurricane seasons.
- Assess participating in the Governor's Hurricane Conference.
- Encourage faith and community-based organizations to become ACCESS partners to enable individuals and families to obtain benefits in their local areas in times of disaster.
- Encourage faith and community-based organizations to become certified as Community Emergency Response Teams (CERT).
- Support efforts of Volunteer Florida to enlist organizations to serve in times of disaster.

Family Initiatives Workgroup

Led by Mr. Richard Alberston, the Family Initiative Workgroup assisted in advancing efforts on topics to include family preservation, healthy marriage, fatherhood, single parent famlies, and other family related issues such as employment and homelessness. The workgroup brings together state agency liaisons and various faith-based and community-based organizations to identify needs, gaps in services and proposed solutions in order to facilitate a more collaborative and coordinated approach to strengthening families.

Progress made throughout 2016 includes:

- Developed a website in targeted areas to list and promote faith and community-based organizations that offer free training/meetings to strengthen relationships and support families.
- Supported fatherhood initiatives and activities in Florida and highlighted organizations for their efforts. Promoted the Department of Education's initiative of *Dads Take Your Child To School Day.*
- Support county health department efforts to engage faith organizations to integrate healthy activities and choices.
- Supported the Department of Agriculture and Consumer Services' efforts to enlist organizations to serve as summer meal sponsors and sites to reduce the number of children who do not have access to healthy foods during the summer.

Areas of focus for 2017 include:

- Develop a partnership with All Pro Dads and bring together various fatherhood groups to share information, ideas and resources.
- Continue to build a relationship with DOH and county health departments to support their efforts to engage faith and community organizations to promote healthy weight initiatives, nutrition and chronic disease prevention.
- Encourage faith organizations to establish resource rooms where health, education and other information can be accessed by individuals and families.
- Encourge organizations to support adoption finalizations, child reunifications, and home visiting graduates.
- Explore opportunities to conduct presentations at Florida conferences on healthy relationships and marrages.
- Support efforts of Farm Share through their free food distributions statewide.

Legislative Workgroup

Led by Pastor Pam Olsen, the Legislative Workgorup works closely with all Advisory Council workgroups to research and identify recommendations to refine, improve, and strengthen policies and legislation affecting Advisory Council workgroup areas of focus and faith-based and community-based organizations.

Areas of focus for 2017 include:

- Work with the Governor's Legislative Office and the Office on Policy and Budge to identify legislation that aligns with Advisory Council efforts.
- Assess opportunities for the Advisory Council to write a letter of support for specific legislation.
- Work to key Advisory Council members updated with bills during the 2017 Legislative Session.

Florida's Five-Year Prevention and Permanency Plan

The Advisory Council continues to support and promote efforts of the *Florida Child Abuse Prevention and Permanency Plan*. The central focus of the plan is to build resilience in all of Florida's families and communities to equip them to better care for and nurture their children. In accordance with state law (Florida Statute 39.001), the five-year prevention and permanency plan provides for the prevention of child abuse, abandonment and neglect; promotion of adoption; and for the support of adoptive families.

Vision

Florida's highest priority is that children are raised in healthy, safe, stable, and nurturing families.

Mission

To serve as a blueprint that will be implemented to provide for the care, safety, and protection of **all** of Florida's children in an environment that fosters healthy social, emotional, intellectual, and physical development.

Overarching Goal

All families and communities ensure that children are safe and nurtured and live in stable environments that promote well-being.

Advisory Council Support

The Advisory Council continues to participate in the following sections of the five-year plan: Prevention of Child Maltreatment, Promotion of Adoption, and Support of Adoptive Families. The following activities occurred through 2016 in support of the plan:

- Disseminated information to create awareness of Protective Factors during quarterly meetings.
- Supported and participated in the Pinwheels for Prevention campaign and disseminated Family Development Guides provided by Prevent Child Abuse Florida during Child Abuse Prevention month.
- Promoted adoption of children from foster care and had chief executive officers, from CBC Lead Agencies, present information on initiatives to recruit foster and adoptive parents during quarterly meetings.
- Members have attended association meetings and worked to facilitate connection to support adoptive families.
- The Advisory Council continues to collaborate with DCF and DJJ to host the annual Faith Symposium to highlight opportunities for faith and community-based organizations to work collaboratively with government entities. The Council also continues to support efforts to have best and promising practice approaches presented at the Faith Symposium.

Citizens Review Panel

The Child Abuse Prevention and Treatment Act (CAPTA) provides federal funding to states for child abuse and neglect prevention, treatment and training for staff who work in the child protection system. The Department of Children and Families (DCF) serves as the lead agency for the federal funding. The Advisory Council serves as a Citizens Review Panel to support DCF's efforts to refine, improve and strengthen the child welfare system.

Citizen Review Panels were included in the 1996 CAPTA reauthorization and must:

- Be composed of volunteers who are representative of the community in which they operate.
- Meet at least quarterly.
- Prepare an annual report that describes the panel's activities and includes recommendations to improve the child protection system.
- Have at least one member with expertise in child abuse and neglect prevention and treatment.

Each panel is responsible to review:

- Compliance of state and local child protection service agencies and state CAPTA plan
- Coordination with foster care and adoption programs
- Review of child fatalities and near fatalities (performed by the Child Abuse Death Review Team)

The Advisory Council was formally designated as a Citizens Review Panel for the Federal Fiscal Year 2016. Below are recommendations provided to DCF:

- Work with the Department of Corrections to certify programs delivered by faith and community-based organizations to meet court and case plans of incarcerated parents.

- Work with Community-Based Care Lead Agencies and providers to have one representative present at local foster and adoptive parent association meetings to provide updates, address questions and facilitate connections for services and supports.

- Work with Community-Based Care Lead Agencies and providers to identify mechanisms that can create efficiencies with their efforts to provide training to become licensed foster or adoptive parents.

- Encourage in-person presentations at the local level to Head Start providers, early learning providers and schools to reinforce online training on signs and responsibilities associated with child abuse reporting.

- Provide and encourage local presentations and training opportunities for early care and education programs, schools, faith and community-based organizations to build protective factors and strengthen protective capacities within parents and caregivers.

ADVISORY COUNCIL RECOMMENDATIONS

The following recommendations are provided to address requirements outlined in Florida Statute 14.31.

1. **How faith-based and community-based organizations can best compete with other organizations for the delivery of state services, regardless of an organization's orientation, whether faith-based or secular.**

   Faith-based and community-based organizations are uniquely positioned in communities, ready to move forward in providing services to those who may be in need. In order to best compete for the delivery of state services, these organizations must first be aware of opportunities available through the state and attend necessary training(s) to ensure they understand state expectations and have the capacity to meet financial, operational, and compliance requirements. These organizations should consider accessing available opportunities through the My Florida Marketplace – Vendor Bid System website and register and/or sign-up to receive electronic notifications about bid advertisements. When applying to perform services for the state, it is encouraged for these organizations to articulate how they may be able to leverage funding streams and potential volunteers to maximize funds from the state to achieve desired outcomes. The Advisory Council will work to post links to the My Florida Marketplace website to enable interested parties to access information available. Additionally, the Advisory Council will continue to work to better locate and identify available funding opportunities for interested parties.

2. **How best to develop and coordinate activities of faith-based and community-based programs and initiatives, enhance such efforts in communities, and seek such resources, legislation, and regulatory relief as may be necessary to accomplish these objectives.**

   One of the first challenges to overcome when working to develop and coordinate activities of faith-based and community-based programs is to be aware of what is being provided. The Advisory Council continues to work on creating awareness of its functions and ability to provide support to organizations. During quarterly meetings, the Advisory Council seeks presentations on best practice approaches and innovative programs, and recognizes organizations for their efforts to strengthen children and families in Florida. This is done to spur ideas in other areas of the state and to develop additional local connections to support activities. Council members serve as regional points of contact for organizations throughout Florida and can assist in facilitating connections to agency staff to build upon the activities.

3. **How best to ensure that state policy decisions take into account the capacity of faith-based and other community-based initiatives to assist in the achievement of state priorities.**

   The Advisory Council encourages elected officials and state agencies to establish review criteria that includes assessment of faith-based and community-based initiatives when determining state policy. Officials and agencies are encouraged to utilize the Advisory Council as a mechanism to disseminate information on proposed changes, community meetings, etc. that can illicit comment and feedback on state policy decisions from faith-based and community-based organizations

4. **How best to identify and promote best practices across state government relating to the delivery of services by faith-based and other community-based organizations.**

   Each year, the Advisory Council, in collaboration with DCF and DJJ, disseminates information to faith-based and community-based organizations to encourage submission of presentations for the

annual Faith Symposium on best practice approaches to improve outcomes. Additionally, once activities are identified, members either facilitate connections directly to state agency contacts or works with the Governor's Office of Adoption and Child Protection for guidance on who best to connect with.

5. **How best to coordinate public awareness of faith-based and community nonprofit initiatives, such as demonstration pilot programs or projects, public-private partnerships, volunteerism, and special projects.**

   The Advisory Council will continue to utilize its quarterly meetings as a platform to highlight and bring attention to initiatives that are making a positive impact in communities and on families. The Advisory Council will also engage the Circuit Task Forces from throughout the state to provide feedback on initiatives that can raise awareness and inform where individuals and families can go for services and supports.

6. **How best to encourage private charitable giving to support faith-based and community-based initiatives.**

   The Advisory Council will continue to work to become informed of initiatives and seek opportunities to facilitate connections to businesses and organizations who can consider supporting such initiatives. The Advisory Council also supports the use of development professionals and consultants who can strategize to achieve financial/in-kind goals.

7. **How best to bring concerns, ideas, and policy options to the Governor and Legislature for assisting, strengthening, and replicating successful faith-based and other community-based programs.**

   The Advisory Council will continue to communicate with state agency liaisons and staff, legislative leaders and staff, and through the Governor's Office of Adoption and Child Protection to bring concerns, ideas, and policy options to the Governor and Legislature. Council members may also work directly with their local legislative delegation to create awareness of concerns, ideas and policy options. Additionally, the Advisory Council will continue to seek comment and input from faith-based and community-based organizations to assess and consider including as part of their recommendations to the Governor and Legislature.

8. **How best to develop and implement strategic initiatives to strengthen the institutions of families and communities in this state.**

   The workgroups established by the Advisory Council are designed to coordinate and facilitate connections that can strengthen communities and families. Additionally, the Advisory Council will continue to work with state agency liaisons to identify opportunities to develop and implement initiatives that can strengthen the institutions of families and communities. The Advisory Council will continue to support the efforts of the Florida Children and Youth Cabinet and other state associations and groups to develop and implement strategic initiatives.

9. **How best to showcase and herald innovative grassroots nonprofit organizations and civic initiatives.**

   The Advisory Council will continue to highlight innovation organizations and civic initiatives at quarterly meetings, local events, state conferences, through the Champion of Hope Award provided at the annual Faith Symposium, and encourage submission of nominations for the Champions of Service Award provided by Volunteer Florida.

10. **How best to eliminate unnecessary legislative, regulatory, and other bureaucratic barriers that impede effective faith-based and other community-based efforts to address social problems.**

    The Advisory Council will continue to seek comment and input from faith and community-based leaders and members on topics regarding legislative, regulatory and other bureaucratic barriers that may impede effective efforts to address social problems. The public comment portion of the Advisory Council meeting is specifically designed for feedback and perspectives to be shared in order to provide information to make necessary recommendations to eliminate such barriers. The Advisory Council will continue to work with state agency contacts and elected officials to eliminate barriers that may impede efforts to strengthen communities and families.

11. **How best to monitor implementation of state policy affecting faith-based and other community-based organizations.**

    Through the collaboration and engagement of state agency liaisons, the Advisory Council will continue working to identify state policies that may affect the efforts of faith-based and other community-based organizations. The Advisory Council's Legislative Workgroup will also seek to monitor implementation of such policies in order to make recommendations that can result in increased collaboration and coordination between faith-based, volunteer and community-based organizations and the state.

12. **How best to ensure that the efforts of faith-based and other community-based organizations meet objective criteria for performance and accountability.**

    The Advisory Council will continue to make itself available to assist faith-based and community-based organizations and work with state agency liaisons and staff to provide technical assistance and training to meet objective criteria for performance and accountability.

Appendix

Florida Faith-Based and Community-Based Advisory Council
Florida Statute 14.31

(1) LEGISLATIVE FINDINGS.—The Legislature finds that:

(a) Compassionate groups of individuals have selflessly aided this state in serving our most vulnerable residents and our most debilitated neighborhoods.

(b) Inspired by faith and civic commitment, these organizations have accomplished much in changing the lives of thousands and resurrecting neighborhoods torn by the strife of crime and poverty.

(c) It is essential that this state cooperate with these organizations in order to provide an opportunity to participate on an equal basis, regardless of each organization's orientation, whether faith-based or secular.

(2) LEGISLATIVE INTENT.—It is therefore the intent of the Legislature to recognize the contributions of these organizations and to encourage opportunities for faith-based and community-based organizations to work cooperatively with government entities in order to deliver services more effectively. The Legislature further intends that the purpose of the council is to advise the Governor and the Legislature on policies, priorities, and objectives for the state's comprehensive effort to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community organizations to the full extent permitted by law.

(3) ESTABLISHMENT OF THE COUNCIL.—

(a) The Florida Faith-based and Community-based Advisory Council, an advisory council as defined in s. 20.03, is established and assigned to the Executive Office of the Governor. The council shall be administratively housed within the Executive Office of the Governor.

(b) The council shall consist of 25 members. Council members may include, but need not be limited to, representatives from various faiths, faith-based organizations, community-based organizations, foundations, corporations, and municipalities.

(c) The council shall be composed of the following members:
1. Seventeen members appointed by and serving at the pleasure of the Governor.
2. Four members appointed by and serving at the pleasure of the President of the Senate.
3. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

(d) Council members shall serve 4-year terms, except that the initial terms shall be staggered as follows:
1. The Governor shall appoint six members for a term of 3 years, six members for a term of 2 years, and five members for a term of 1 year.
2. The President of the Senate shall appoint two members for a term of 3 years and two members for a term of 2 years.
3. The Speaker of the House of Representatives shall appoint two members for a term of 3 years and two members for a term of 2 years.

(e) A vacancy shall be filled by appointment by the original appointing authority for the unexpired portion of the term.

(4) MEETINGS; ORGANIZATION.—

(a) The first meeting of the council shall be held no later than August 1, 2006. Thereafter, the council shall meet at least once per quarter per calendar year. Meetings may be held via teleconference or other electronic means.

(b) The council shall annually elect from its membership one member to serve as chair of the council and one member to serve as vice chair.

(c) Thirteen members of the council shall constitute a quorum.

(d) Members of the council shall serve without compensation but may be reimbursed for per diem and travel expenses pursuant to s. 112.061.

(5) SCOPE OF ACTIVITIES.—The council shall review and recommend in a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives:

(a) How faith-based and community-based organizations can best compete with other organizations for the delivery of state services, regardless of an organization's orientation, whether faith-based or secular.

(b) How best to develop and coordinate activities of faith-based and community-based programs and initiatives, enhance such efforts in communities, and seek such resources, legislation, and regulatory relief as may be necessary to accomplish these objectives.

(c) How best to ensure that state policy decisions take into account the capacity of faith-based and other community-based initiatives to assist in the achievement of state priorities.

(d) How best to identify and promote best practices across state government relating to the delivery of services by faith-based and other community-based organizations.

(e) How best to coordinate public awareness of faith-based and community nonprofit initiatives, such as demonstration pilot programs or projects, public-private partnerships, volunteerism, and special projects.

(f) How best to encourage private charitable giving to support faith-based and community-based initiatives.

(g) How best to bring concerns, ideas, and policy options to the Governor and Legislature for assisting, strengthening, and replicating successful faith-based and other community-based programs.

(h) How best to develop and implement strategic initiatives to strengthen the institutions of families and communities in this state.

(i) How best to showcase and herald innovative grassroots nonprofit organizations and civic initiatives.

(j) How best to eliminate unnecessary legislative, regulatory, and other bureaucratic barriers that impede effective faith-based and other community-based efforts to address social problems.

(k) How best to monitor implementation of state policy affecting faith-based and other community-based organizations.

(l) How best to ensure that the efforts of faith-based and other community-based organizations meet objective criteria for performance and accountability.

(6) RESTRICTED ACTIVITIES.—The council may not make any recommendation that conflicts with the Establishment Clause of the First Amendment to the United States Constitution or the public funding provision of s. 3, Art. I of the State Constitution.

(7) REPORT.—By February 1 of each year, the council shall prepare a written report for the Governor, the President of the Senate, and the Speaker of the House of Representatives containing an accounting of its activities and recommended policies, priorities, and objectives for the state's comprehensive effort to enlist, equip, enable, empower, and expand the work of faith-based, volunteer, and other community-based organizations to the full extent permitted by law.

History.—s. 1, ch. 2006-9; s. 1, ch. 2011-155.

Governor's Office of Adoption and Child Protection
Florida Statute 39.001, Sections 8 – 12

(8) LEGISLATIVE INTENT FOR THE PREVENTION OF ABUSE, ABANDONMENT, AND NEGLECT OF CHILDREN.—The incidence of known child abuse, abandonment, and neglect has increased rapidly over the past 5 years. The impact that abuse, abandonment, or neglect has on the victimized child, siblings, family structure, and inevitably on all citizens of the state has caused the Legislature to determine that the prevention of child abuse, abandonment, and neglect shall be a priority of this state. To further this end, it is the intent of the Legislature that an Office of Adoption and Child Protection be established.

(9) OFFICE OF ADOPTION AND CHILD PROTECTION.—

(a) For purposes of establishing a comprehensive statewide approach for the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect, the Office of Adoption and Child Protection is created within the Executive Office of the Governor. The Governor shall appoint a Chief Child Advocate for the office.

(b) The Chief Child Advocate shall:

1. Assist in developing rules pertaining to the promotion of adoption, support of adoptive families, and implementation of child abuse prevention efforts.

2. Act as the Governor's liaison with state agencies, other state governments, and the public and private sectors on matters that relate to the promotion of adoption, support of adoptive families, and child abuse prevention.

3. Work to secure funding and other support for the state's promotion of adoption, support of adoptive families, and child abuse prevention efforts, including, but not limited to, establishing cooperative relationships among state and private agencies.

4. Develop a strategic program and funding initiative that links the separate jurisdictional activities of state agencies with respect to promotion of adoption, support of adoptive families, and child abuse prevention. The office may designate lead and contributing agencies to develop such initiatives.

5. Advise the Governor and the Legislature on statistics related to the promotion of adoption, support of adoptive families, and child abuse prevention trends in this state; the status of current adoption programs and services, current child abuse prevention programs and services, the funding of adoption, support of adoptive families, and child abuse prevention programs and services; and the status of the office with regard to the development and implementation of the state strategy for the promotion of adoption, support of adoptive families, and child abuse prevention.

6. Develop public awareness campaigns to be implemented throughout the state for the promotion of adoption, support of adoptive families, and child abuse prevention.

(c) The office is authorized and directed to:

1. Oversee the preparation and implementation of the state plan established under subsection (10) and revise and update the state plan as necessary.
2. Provide for or make available continuing professional education and training in the prevention of child abuse and neglect.

3. Work to secure funding in the form of appropriations, gifts, and grants from the state, the Federal Government, and other public and private sources in order to ensure that sufficient funds are available for the promotion of adoption, support of adoptive families, and child abuse prevention efforts.

4. Make recommendations pertaining to agreements or contracts for the establishment and development of:

    a. Programs and services for the promotion of adoption, support of adoptive families, and prevention of child abuse and neglect.

    b. Training programs for the prevention of child abuse and neglect.

    c. Multidisciplinary and discipline-specific training programs for professionals with responsibilities affecting children, young adults, and families.

    d. Efforts to promote adoption.

    e. Postadoptive services to support adoptive families.

5. Monitor, evaluate, and review the development and quality of local and statewide services and programs for the promotion of adoption, support of adoptive families, and prevention of child abuse and neglect and shall publish and distribute an annual report of its findings on or before January 1 of each year to the Governor, the Speaker of the House of Representatives, the President of the Senate, the head of each state agency affected by the report, and the appropriate substantive committees of the Legislature. The report shall include:

    a. A summary of the activities of the office.

    b. A summary of the adoption data collected and reported to the federal Adoption and Foster Care Analysis and Reporting System (AFCARS) and the federal Administration for Children and Families.

    c. A summary of the child abuse prevention data collected and reported to the National Child Abuse and Neglect Data System (NCANDS) and the federal Administration for Children and Families.

    d. A summary detailing the timeliness of the adoption process for children adopted from within the child welfare system.

    e. Recommendations, by state agency, for the further development and improvement of services and programs for the promotion of adoption, support of adoptive families, and prevention of child abuse and neglect.

    f. Budget requests, adoption promotion and support needs, and child abuse prevention program needs by state agency.

6. Work with the direct-support organization established under s. 39.0011 to receive financial assistance.

(10) PLAN FOR COMPREHENSIVE APPROACH.—

(a) The office shall develop a state plan for the promotion of adoption, support of adoptive families, and prevention of abuse, abandonment, and neglect of children and shall submit the state plan to the Speaker of the House of Representatives, the President of the Senate, and the Governor no later than December 31, 2008. The Department of Children and Families, the Department of Corrections, the Department of Education, the Department of Health, the Department of Juvenile Justice, the Department of Law Enforcement, and the Agency for Persons with Disabilities shall participate and fully cooperate in the development of the state plan at both the state and local levels. Furthermore, appropriate local agencies and organizations shall be provided an opportunity to participate in the development of the state plan at the local level. Appropriate local groups and organizations shall include, but not be limited to, community mental health centers; guardian ad litem programs for children under the circuit court; the school boards of the local school districts; the Florida local advocacy councils; community-based care lead agencies; private or public organizations or programs with recognized expertise in working with child abuse prevention programs for children and families; private or public organizations or programs with recognized expertise in working with children who are sexually abused, physically abused, emotionally abused, abandoned, or neglected and with expertise in working with the families of such children; private or public programs or organizations with expertise in maternal and infant health care; multidisciplinary child protection teams; child day care centers; law enforcement agencies; and the circuit courts, when guardian ad litem programs are not available in the local area. The state plan to be provided to the Legislature and the Governor shall include, as a minimum, the information required of the various groups in paragraph (b).

(b) The development of the state plan shall be accomplished in the following manner:

1. The office shall establish a Child Abuse Prevention and Permanency Advisory Council composed of an adoptive parent who has adopted a child from within the child welfare system and representatives from each state agency and appropriate local agencies and organizations specified in paragraph (a). The advisory council shall serve as the research arm of the office and shall be responsible for:

   a. Assisting in developing a plan of action for better coordination and integration of the goals, activities, and funding pertaining to the promotion and support of adoption and the prevention of child abuse, abandonment, and neglect conducted by the office in order to maximize staff and resources at the state level. The plan of action shall be included in the state plan.

   b. Assisting in providing a basic format to be utilized by the districts in the preparation of local plans of action in order to provide for uniformity in the district plans and to provide for greater ease in compiling information for the state plan.

   c. Providing the districts with technical assistance in the development of local plans of action, if requested.

   d. Assisting in examining the local plans to determine if all the requirements of the local plans have been met and, if they have not, informing the districts of the deficiencies and requesting the additional information needed.

   e. Assisting in preparing the state plan for submission to the Legislature and the Governor. Such preparation shall include the incorporation into the state plan of information obtained from the local plans, the cooperative plans with the members of the advisory council, and the plan of action for coordination and integration of state

departmental activities. The state plan shall include a section reflecting general conditions and needs, an analysis of variations based on population or geographic areas, identified problems, and recommendations for change. In essence, the state plan shall provide an analysis and summary of each element of the local plans to provide a statewide perspective. The state plan shall also include each separate local plan of action.

f. Conducting a feasibility study on the establishment of a Children's Cabinet.

g. Working with the specified state agency in fulfilling the requirements of subparagraphs 2., 3., 4., and 5.

2. The office, the department, the Department of Education, and the Department of Health shall work together in developing ways to inform and instruct parents of school children and appropriate district school personnel in all school districts in the detection of child abuse, abandonment, and neglect and in the proper action that should be taken in a suspected case of child abuse, abandonment, or neglect, and in caring for a child's needs after a report is made. The plan for accomplishing this end shall be included in the state plan.

3. The office, the department, the Department of Law Enforcement, and the Department of Health shall work together in developing ways to inform and instruct appropriate local law enforcement personnel in the detection of child abuse, abandonment, and neglect and in the proper action that should be taken in a suspected case of child abuse, abandonment, or neglect.

4. Within existing appropriations, the office shall work with other appropriate public and private agencies to emphasize efforts to educate the general public about the problem of and ways to detect child abuse, abandonment, and neglect and in the proper action that should be taken in a suspected case of child abuse, abandonment, or neglect. The plan for accomplishing this end shall be included in the state plan.

5. The office, the department, the Department of Education, and the Department of Health shall work together on the enhancement or adaptation of curriculum materials to assist instructional personnel in providing instruction through a multidisciplinary approach on the identification, intervention, and prevention of child abuse, abandonment, and neglect. The curriculum materials shall be geared toward a sequential program of instruction at the four progressional levels, K-3, 4-6, 7-9, and 10-12. Strategies for encouraging all school districts to utilize the curriculum are to be included in the state plan for the prevention of child abuse, abandonment, and neglect.

6. Each district of the department shall develop a plan for its specific geographical area. The plan developed at the district level shall be submitted to the advisory council for utilization in preparing the state plan. The district local plan of action shall be prepared with the involvement and assistance of the local agencies and organizations listed in this paragraph, as well as representatives from those departmental district offices participating in the promotion of adoption, support of adoptive families, and treatment and prevention of child abuse, abandonment, and neglect. In order to accomplish this, the office shall establish a task force on the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect. The office shall appoint the members of the task force in accordance with the membership requirements of this section. The office shall ensure that individuals from both urban and rural areas and an adoptive parent who has adopted a child from within the child welfare system are represented on the task force. The task force shall develop a written statement clearly identifying its operating procedures,

purpose, overall responsibilities, and method of meeting responsibilities. The district plan of action to be prepared by the task force shall include, but shall not be limited to:

a. Documentation of the magnitude of the problems of child abuse, including sexual abuse, physical abuse, and emotional abuse, and child abandonment and neglect in its geographical area.

b. A description of programs currently serving abused, abandoned, and neglected children and their families and a description of programs for the prevention of child abuse, abandonment, and neglect, including information on the impact, cost-effectiveness, and sources of funding of such programs.

c. Information concerning the number of children within the child welfare system available for adoption who need child-specific adoption promotion efforts.

d. A description of programs currently promoting and supporting adoptive families, including information on the impact, cost-effectiveness, and sources of funding of such programs.

e. A description of a comprehensive approach for providing postadoption services. The continuum of services shall include, but not be limited to, sufficient and accessible parent and teen support groups; case management, information, and referral services; and educational advocacy.

f. A continuum of programs and services necessary for a comprehensive approach to the promotion of adoption and the prevention of all types of child abuse, abandonment, and neglect as well as a brief description of such programs and services.

g. A description, documentation, and priority ranking of local needs related to the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect based upon the continuum of programs and services.

h. A plan for steps to be taken in meeting identified needs, including the coordination and integration of services to avoid unnecessary duplication and cost, and for alternative funding strategies for meeting needs through the reallocation of existing resources, utilization of volunteers, contracting with local universities for services, and local government or private agency funding.

i. A description of barriers to the accomplishment of a comprehensive approach to the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect.

j. Recommendations for changes that can be accomplished only at the state program level or by legislative action.

(11) FUNDING AND SUBSEQUENT PLANS.—

(a) All budget requests submitted by the office, the department, the Department of Health, the Department of Education, the Department of Juvenile Justice, the Department of Corrections, the Agency for Persons with Disabilities, or any other agency to the Legislature for funding of efforts for the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect shall be based on the state plan developed pursuant to this section.

(b) The office and the other agencies and organizations listed in paragraph (10)(a) shall readdress the state plan and make necessary revisions every 5 years, at a minimum. Such revisions shall be submitted to the Speaker of the House of Representatives and the President of the Senate no later than June 30 of each year divisible by 5. At least biennially, the office shall review the state plan and make any necessary revisions based on changing needs and program evaluation results. An annual progress report shall be submitted to update the state plan in the years between the 5-year intervals. In order to avoid duplication of effort, these required plans may be made a part of or merged with other plans required by either the state or Federal Government, so long as the portions of the other state or Federal Government plan that constitute the state plan for the promotion of adoption, support of adoptive families, and prevention of child abuse, abandonment, and neglect are clearly identified as such and are provided to the Speaker of the House of Representatives and the President of the Senate as required under this section.

(12) LIBERAL CONSTRUCTION.—It is the intent of the Legislature that this chapter be liberally interpreted and construed in conformity with its declared purposes.

History.—s. 1, ch. 26880, 1951; s. 1, ch. 73-231; s. 1, ch. 78-414; s. 1, ch. 82-62; s. 62, ch. 85-81; s. 1, ch. 85-206; s. 10, ch. 85-248; s. 19, ch. 86-220; s. 1, ch. 90-53; ss. 1, 2, ch. 90-208; s. 2, ch. 90-306; s. 2, ch. 91-33; s. 68, ch. 91-45; s. 13, ch. 91-57; s. 5, ch. 93-156; s. 23, ch. 93-200; s. 19, ch. 93-230; s. 14, ch. 94-134; s. 14, ch. 94-135; ss. 9, 10, ch. 94-209; s. 1332, ch. 95-147; s. 7, ch. 95-152; s. 8, ch. 95-158; ss. 15, 30, ch. 95-228; s. 116, ch. 95-418; s. 1, ch. 96-268; ss. 128, 156, ch. 97-101; s. 69, ch. 97-103; s. 3, ch. 97-237; s. 119, ch. 97-238; s. 8, ch. 98-137; s. 18, ch. 98-403; s. 1, ch. 99-193; s. 13, ch. 2000-139; s. 5, ch. 2000-151; s. 5, ch. 2000-263; s. 34, ch. 2004-267; s. 2, ch. 2006-97; s. 1, ch. 2006-194; s. 2, ch. 2006-227; s. 1, ch. 2007-124; s. 3, ch. 2008-6; s. 1, ch. 2010-114; s. 42, ch. 2011-142; s. 2, ch. 2012-105; s. 19, ch. 2012-116; s. 4, ch. 2013-15; s. 9, ch. 2014-19; s. 2, ch. 2014-224.

Note.—Former s. 39.20; subsections (3), (5), and (6) former s. 39.002, s. 409.70, subsections (7)-(9) former s. 415.501.

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Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

Annual Report

December 2016

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MISSION:

To eliminate preventable child abuse and neglect deaths

Submitted to:

The Honorable Rick Scott, Governor, State of Florida
The Honorable Joe Negron, President, Florida State Senate
The Honorable Richard Corcoran, Speaker, Florida State House of Representatives

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Appendices

EXECUTIVE SUMMARY

Florida's Child Abuse Death Review Process

Section 383.402, Florida Statutes (FS), authorizes the State and Local Child Abuse Death Review (CADR) Committees and mandates guidelines for membership and duties. The Florida CADR System was established in Florida law in 1999. The program is administered by the Florida Department of Health (DOH) and utilizes Local CADR committees to conduct detailed reviews of the facts and circumstances surrounding child deaths reported to the Florida Abuse Hotline and accepted for investigation. The State CADR Committee collects and analyzes data from the local reviews and prepares an annual statistical report, which is submitted to the Governor, President of the Senate, and Speaker of the House of Representatives.

The purpose of the CADR process is to:

- Develop a community-based approach to address child abuse deaths and contributing factors;
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect;
- Identify gaps, deficiencies, or problems in service delivery to children and families by public and private agencies that may be related to child abuse deaths;
- Develop data-driven recommendations for reducing child abuse and neglect deaths; and
- Implement such recommendations, to the extent possible.

Since the inception of the CADR system, changes in statutory requirements have gradually widened the scope of child fatality cases committees are expected to review. Currently, local committees conduct case reviews on all child fatalities reported to the Florida Abuse Hotline, including those investigated and found **verified** as child maltreatment as well as those **not verified** as maltreatment. This expanded scope has allowed the state committee to review additional data sets that can be used to inform statewide and local prevention strategies aimed at reducing child abuse and neglect deaths in Florida.

2015 Data: Case Review Analyses

Throughout 2016, the death review system conducted case reviews on over 349 child fatalities that occurred in 2015. Analyses of 2015 case review data reveal that Florida's youngest children continue to be most vulnerable to child abuse and neglect fatalities. Regardless of verification status, children under five had the highest risk for all forms of death. Additional findings identify three primary preventable causes of child deaths, which remain consistent with findings from previous years:

- **Drowning** continues to be a primary cause of preventable death among children in Florida. Unsupervised access to pools, spas/tubs, and open bodies of water remains a potential threat to child safety.
- **Asphyxia,** often the result of unsafe sleep practices, claims the lives of younger children.
- **Trauma/wounds caused by a weapon,** primarily the use of firearms or bodily force (e.g., fists and feet) to inflict harm, also ranks in the top three causes of child deaths.

From Analysis to Action

Florida's child welfare system is continuously evolving to meet the needs of a diverse and dynamic population. Years of research showing consistent correlation between child maltreatment and poor health outcomes later in life bring child maltreatment to the forefront as a serious public health issue. As challenges continue to surface, the CADR system has renewed its focus on the need to move beyond data collection and to act on findings at both state and local levels. This trend is evident throughout the state as progressively more local, circuit-based committees actively collaborate with community partners to develop and implement

multi-sector strategies to further prevention initiatives. Public awareness campaigns, improvements in community-based systems of care, enhancements in staff training and programmatic policy, and many other impact-based activities continue to be shaped and informed by CADR findings and recommendations.

Prevention Recommendations

The State CADR Committee developed this year's prevention recommendations based on input and participation from local committee members, an analysis of case review data findings, and a review of literature and the most current research on prevention strategies as outlined by our nation's foremost experts. Prevention recommendations were developed and organized using a multi-level social ecological model for change to identify strategies that will address all levels of our social ecology. Strategies geared toward individuals, families and their interpersonal social networks, communities, and society as a whole, seek to create sustainable change as they target the top three primary causes of child fatalities as defined by all data sources.

The following prevention recommendations for 2016 provide a high-level overview of strategies and approaches aimed at eliminating preventable child fatalities in Florida:

- ***Enhance and Support the Integration of Behavioral Health Services into the Child Welfare System:*** Substance use disorders, mental health disorders, and dynamics associated with domestic violence have profoundly negative impacts on parental capacity and child well-being while greatly increasing the risk of child harm. Readily accessible and appropriate interventions for at-risk families dealing with these issues is a critical step toward ensuring a safe, stable, and nurturing environment for children. Behavioral health services in the child welfare system should include an assessment of trauma for children exposed to adverse child experiences (ACE) and appropriate trauma informed interventions to improve short and long-term health outcomes.

- ***Continue to Support Programs that Enhance Parenting Skills:*** Family support programs provide high-risk families with the necessary knowledge, resources, and support to bolster parental protective capacities, thereby increasing child safety. These supports lead to improved outcomes for families including reduction and prevention of child abuse and neglect, reduction in risk factors for abuse and neglect, improved parent-child interaction, increased family stability and self-sufficiency, and improved maternal and child health.

- ***Ensure Clear and Consistent Messaging among Agencies During Efforts to Increase Awareness:*** A wide array of agencies and organizations are actively involved in prevention messaging. While all stakeholders are striving toward similar goals, inconsistencies in messaging can and do occur. Consistency in messaging, particularly those communications designed to encourage prevention-oriented behaviors, eliminates confusion among caregivers and sends a stronger, more unified message to the general public. The consistency of Florida's prevention messaging is a priority at the state and local levels and requires active collaboration and communication between agencies to ensure alignment of content.

- ***Encourage Collaborative Partnerships at both the State and Community Levels:*** Interagency and community stakeholder partnerships must be established and maintained at both the state and local levels. Truly collaborative partnerships encourage the sharing of data and information by establishing reliable streams of communication between agencies and organizations. Active collaboration encourages the pooling of resources, reinforces the alignment of prevention planning, and ensures the consistency of collective prevention messaging informed by research literature, and state/federal agency.

- ***Explore the Value and Utility of Existing Prevention Activities Throughout Florida:*** The value and utility of current prevention initiatives and efforts should be fully explored. Strategies and approaches that show promise and appear to have positive impacts on prevention efforts should be considered for replication in other areas within the state. Resources including tools, templates, and promising practices should be shared among local committees to further attempt to reduce duplication of effort and encourage consistent messaging throughout the state.

- ***Support the Development of Toolkits to Assist in the Planning and Development of Prevention Activities:*** Various toolkits should be developed to help address specified hot topics, such as water safety awareness, safe sleep initiatives, bolstering protective factors to increase parental capacity, and tips and techniques for fostering community collaboration. These toolkits should be developed based on standards and recommendations acknowledged by research, professional literature, and/or existing state and federal agencies.

- ***Offer Training and Technical Assistance to Circuits Regarding How to Leverage Data to Inform and Improve Practice:*** Training and technical assistance should be offered to those circuits most interested in delving into their own localized data to further identify contributing factors specific to their community. This training should incorporate information on how to leverage available data tools, training on basic data analysis techniques, and instruction on action planning. All circuits and stakeholders should be provided with guidance regarding how to best leverage the findings of this report to develop sound and effective prevention techniques designed to meet the specific needs of their areas.

The implementation of these comprehensive prevention strategies will provide the momentum needed to work toward our ultimate goal:

To eliminate preventable child fatalities in Florida by better understanding the complexities of child maltreatment and leveraging this evidence-based knowledge to drive current and future prevention strategies.

SECTION ONE: BACKGROUND

PROGRAM DESCRIPTION

The Florida CADR System was established in Florida law in 1999. The program is administered by DOH and utilizes local CADR committees to conduct detailed reviews of the facts and circumstances surrounding child deaths reported to the Florida Abuse Hotline and accepted for investigation. The State CADR Committee collects and analyzes data from the local reviews, and prepares an annual statistical report, which is submitted to the Governor, President of the Senate and Speaker of the House of Representatives.

STATUTORY AUTHORITY

Section 383.402, FS, authorizes the State and local CADR committees and mandates guidelines for membership and duties. The state committee was initially authorized to review only verified child abuse deaths with at least one prior report to the Florida Abuse Hotline. After several years, it was determined that the requirement for a prior report limited the committee's ability to review infant deaths, and in 2004 reviews were expanded to include all verified child abuse or neglect deaths. The legislature expanded the reviews even further in 2014, and currently the local and state committees review all child deaths reported to the Florida Abuse Hotline. Section 383.402, FS, is referenced in Appendix A.

PROGRAM PURPOSE

The purpose of the CADR process is to:

- Develop a community-based approach to address child abuse deaths and contributing factors;
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect;
- Identify gaps, deficiencies, or problems in service delivery to children and families by public and private agencies that may be related to child abuse deaths;
- Develop data-driven recommendations for reducing child abuse and neglect deaths; and
- Implement such recommendations, to the extent possible.

STATE COMMITTEE

The State CADR Committee consists of seven agency representatives and twelve appointments from various disciplines related to the health and welfare of children and families. Members of the State CADR Committee are appointed for staggered two-year terms. All members are eligible for reappointment not to exceed three consecutive terms. The representative of DOH serves as the state committee coordinator.

In addition to DOH, the State CADR Committee is composed of representatives from the following departments, agencies, or organizations:

- Department of Legal Affairs
- Department of Children and Families
- Department of Law Enforcement
- Department of Education
- Florida Prosecuting Attorneys Association
- Florida Medical Examiners Commission, whose representative must be a forensic pathologist

In addition, the State Surgeon General is responsible for appointing the following members based on recommendations from the agencies listed above; and for ensuring that the committee represents to the greatest possible extent, the regional, gender, and racial/ethnic diversity of the state.

- The Department of Health Statewide Child Protection Team Medical Director
- A public health nurse
- A mental health professional who treats children or adolescents
- An employee of the Department of Children and Families who supervises family services counselors and who has at least five years of experience in child protective investigations
- A medical director of a child protection team
- A member of a child advocacy organization
- A social worker who has experience in working with victims and perpetrators of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A law enforcement officer who has at least five years of experience in children's issues
- A representative of the Florida Coalition Against Domestic Violence
- A representative from a private provider of programs on preventing child abuse and neglect
- A substance abuse treatment professional

For a listing of state committee members, see Appendix B.

The state committee is charged with oversight of the local committees through the establishment of local committee guidelines. Through analysis and discussion of statewide data, the state committee studies the adequacies of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths, develop strategies, and recruit partners to implement these changes at both the state and local levels.

LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES

Local committees have the primary responsibility for reviewing all alleged child abuse and neglect deaths reported to the Florida Abuse Hotline and for presenting information relevant to these deaths to the State CADR Committee through the completion of the Case Report Form. Local committees comprise individuals from agencies within the community who share an interest in promoting, protecting, and improving the health and welfare of children.

Recent Systemic Changes

Local committees have successfully adapted to a number of system changes occurring this year. In January 2015, local committee boundaries were adjusted to realign with judicial circuits. During this transition:

- Several geographical regions were split in such a way that new committees had to completely rebuild membership;
- All local committee members throughout the state were appointed (or re-appointed) to ensure each committee met membership criteria outlined in statute; and
- A significant portion of appointed local committee members were new to the CADR system.

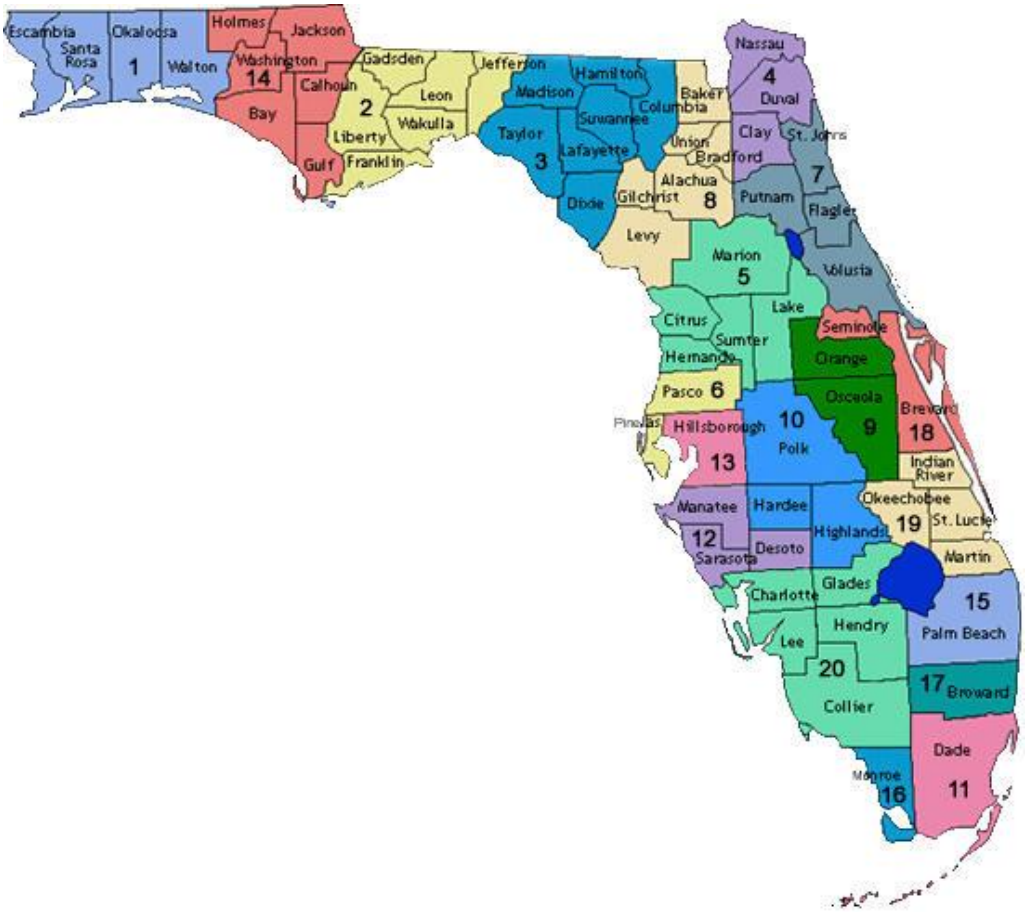
Recent changes in statute direct County Health Officers to appoint, convene, and support CADR committees. Every county has an appointed health officer, and one appointee is designated the lead CADR Health Officer for each circuit. This year brought about the full integration of health officer involvement in the CADR system. Their collective involvement has provided an extra layer of support to committees at the local level.

Membership of Local Committees

At a minimum, representatives from the following organizations are appointed by the CADR health officers:

- The state attorney's office
- The medical examiner's office
- The local Department of Children and Families child protective investigations unit
- Department of Health child protection team
- The community-based care lead agency
- State, county, or local law enforcement agencies
- The school district
- A mental health treatment provider
- A certified domestic violence center
- A substance abuse treatment provider
- Any other members that are listed in guidelines developed by the State CADR Committee

Map of Circuit-based Committees



Case Review Statistics

Case data analyzed for this report includes all information on cases reviewed with data entered into the National Center for the Review & Prevention of Child Deaths database by September 30, 2016. Table 1 details the distribution of 2015 child fatality cases reviewed (stratified by maltreatment verification status), those awaiting review, and those that were not available for review as of September 30, 2016 for each local CADR committee.

Table 1: Child Fatality Cases Reviewed and Case Review Status Across Local CADR Committees

	Total Cases (Child deaths called into hotline)	Cases Not Available for Review (Open investigation/Case still being processed)	Closed Investigation (case available for review)	Review Completed	Verified Maltreatment Cases Reviewed	Non-Verified Maltreatment Cases Reviewed
Circuit #1	23	13	10	7	0	7
Circuit #2	10	4	6	5	1	4
Circuit #3	4	0	4	4	1	3
Circuit #4	43	0	43	42	9	33
Circuit #5	40	1	39	18	3	15
Circuit #6	37	2	35	35	8	27
Circuit #7	19	0	19	19	4	15
Circuit #8	6	0	6	6	1	5
Circuit #9	39	1	38	37	7	30
Circuit #10	40	1	39	36	4	32
Circuit #11	26	16	10	9	3	6
Circuit #12	19	9	10	10	3	7
Circuit #13	30	2	28	28	3	25
Circuit #14	12	9	3	0	0	0
Circuit #15	27	10	17	17	3	14
Circuit #16	0	0	0	0	0	0
Circuit #17	34	7	27	26	9	17
Circuit #18	25	1	24	24	10	14
Circuit #19	13	3	10	10	3	7
Circuit #20	27	7	20	16	7	9
Totals	474	86	388	349	79	270

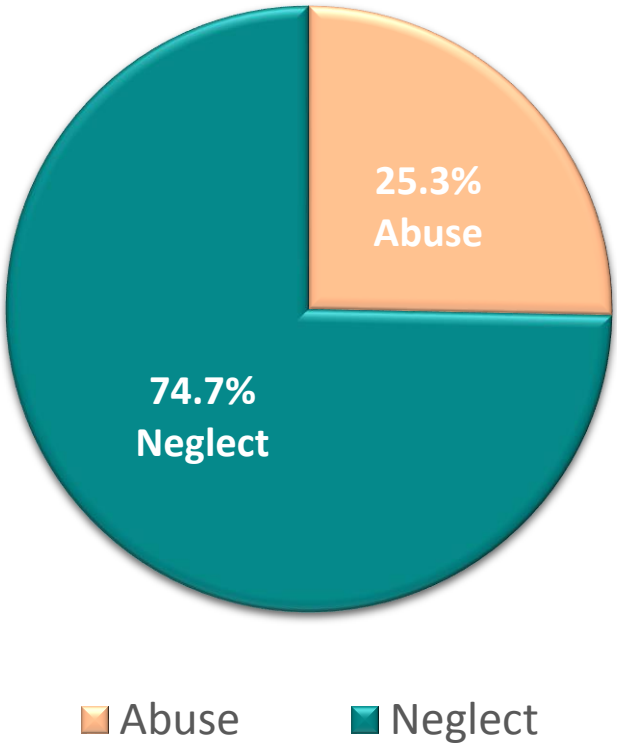
Summary Points:

- 474 child fatalities for 2015 were called into the Florida Abuse Hotline (Data as of 09/30/16)
  - 388 of these cases were closed by the Florida Department of Children and Families (DCF)
  - 86 cases were still open or recently closed for which case information was in the process of being assembled and prepared for review by local CADR committee.
- Of the 388 closed cases for which the information was available for review, 349 had local CADR committee reviews completed, with the remainder of cases (n=39) scheduled for review after September 30, 2016. Please note that this report applies to the 349 cases that local CADR committees completed. Findings are qualified by this fact and may change once all referenced child fatalities are reviewed. Consideration will be given in the future by the State CADR Committee toward

supplemental analyses on 2015 fatalities when the remaining 125 child fatality cases are closed and reviewed by local committees.

- Of the 79 verified maltreatment deaths reviewed, the majority, 59 (74.7%), were a result of neglect and 20 (25.3%) were a result of abuse (see Figure 1 below).

Figure 1: Distribution of Reviewed Verified Maltreatment Deaths by Abuse and Nelgect



SECTION TWO: METHOD

CASE FILE TRANSFER PROCESS IMPROVEMENTS

Significant improvements were made to the CADR case file transfer process during this calendar year. DOH central office staff, in partnership with DCF child fatality prevention staff, developed an improved system of transferring case file information using a secured, web-based site (MoveIt) as the point of transfer. Newly developed procedures streamline the transfer process as case information flows from DCF to DOH and is ultimately distributed to committee chairs. This newly established process improves accountability, ensures security of confidential case information, and provides a reliable mechanism for tracking files as they move through the CADR system. Increased collaboration is also evident during monthly CADR circuit calls, where participation has moved beyond committee chairs to also include CADR health officers, DCF staff, and other interested stakeholders. As a result, communication between all parties has greatly improved.

LOCAL COMMITTEE REVIEWS AND REPORTING PROCESS

For information detailing local CADR committee operating procedures, please see the *Guidelines for Local Committees* denoted in Appendix D. These local guidelines recommend best practices for conducting effective child fatality reviews and highlight the duties and responsibilities of the local CADR committees and members. The State CADR Committee has identified core data to be collected for each case, and has provided detailed guidance on the content of case narratives.

Ideally, committee members reach consensus on the findings from the review and the wording of the final narrative. If consensus is not reached, it should be noted in the narrative summary. Once the review is completed, review data are entered into the Child Death Review Case Reporting System.

THE CADR CYCLE

Florida law directs state and local committees to identify gaps, deficiencies, or problems in the delivery of services to children and their families, and to recommend changes needed to better support the safe and healthy development of children. Local committees are encouraged to take a communitywide approach to address causes and contributing factors of deaths resulting from child abuse, and to implement identified strategies, to the extent possible.

Newly formed circuit-based committees brought about an opportunity to reinforce this goal – to move beyond data collection into collaborative action. During monthly circuit conference calls, training, and technical assistance, local committee members were encouraged to view the collective review process as a cycle, during which data are collected, analyzed and acted upon.

This new framework has enhanced state and local committee members' collective understanding of the need to build upon lessons learned, and supports our efforts to ensure the decision-making is based on applicable data.

SECTION THREE: DATA

It is important for the reader to understand how abuse investigation findings are classified. At the time of the local committee reviews of year 2015 cases, DCF's operating procedures (Child Maltreatment Index) classified the findings from investigations as follows:

- VERIFIED - This finding is used when a preponderance of the credible evidence results in a determination that the specific harm or threat of harm was the result of abuse, abandonment, or neglect.
- NOT SUBSTANTIATED - This finding is used when there is credible evidence, which does not meet the standard of being a preponderance, to support that the specific harm was the result of abuse, abandonment, or neglect.
- NO INDICATORS - This finding is used when there is no credible evidence to support the allegations of abuse, abandonment, or neglect.

Core data elements of case reviews are summarized in this report by child maltreatment verification status. Since all cases were called into the Florida Abuse Hotline for investigation, all tabled data refer to cases as either "verified child maltreatment" death or a "non-verified child maltreatment" death. Non-verified child maltreatment death includes both "not substantiated" and "no indicators" findings.

The state committee also recommended that statewide summary data include:

- Itemization of child fatalities across geographic regions
- Analyses related to the child's age, using one-year intervals through the age of five, followed by four-year or five-year groupings

CHILD DEATH TRENDS

In 2015, the all-cause death rate for children aged 0-17 was 54.4 deaths per 100,000 child population (Florida CHARTS, 2016). The reported 2015 verified child maltreatment death rate in Table 2 is 2.3 per 100,000 child population. This figure should be considered tentative and an underestimate as there are a number of cases (see Table 1) that were still open at DCF and not yet transferred to local CADR committees for which verification status has been determined. Table 2 shows the number and rates of all-cause and verified child maltreatment deaths among children in Florida from 2011-2015 where the child maltreatment death rate (between 2011 and 2014) has ranged from a low of 3.2 (per 100,000) in 2012 to a high of 3.58 (per 100,000) in 2014.

Table 2: Child Deaths: All Causes and Maltreatments Florida, 2011-2014

	Child Deaths All Causes	Child Death Rate per 100,000 Child Population	Verified Child Maltreatment Deaths	Child Maltreatment Death Rate per 100,000 Child Population
2011	2,191	54.7	136	3.40
2012	2,046	50.8	129	3.20
2013	2,105	51.7	137	3.37
2014	2,131	52	147	3.58
2015	2,249	54.4	95*	2.30*

* The number of verified child maltreatment cases for 2015 is not complete given the number of cases still open and not yet transferred to local CADR Committees for review. Past year figures may have changed as cases were closed following the submission of past CADR reports.

CHILD DEATH INCIDENT INFORMATION

The following findings highlight information related to incident data associated with child fatalities, including an itemization of the location (by county) where the incident took place. Each child fatality review itemizes the official manner and primary cause of death, and if the death is ruled a homicide, whether the death is a result of child abuse or neglect. Some deaths classified by the Medical Examiner as accidental on death certificates will, upon investigation, be determined to be the result of neglect.

Table 3 denotes the official manner of death obtained from death certificates for all child fatalities reviewed for this report. Of the 79 child fatalities verified to be the result of abuse and/or neglect, 48 (60.8%) were classified as accidents and 25 (31.6%) were classified as homicides. Among non-verified child maltreatment fatalities, the largest number of deaths (n=108 or 40.0%) were classified as accidents followed by natural causes (n=76 or 28.1%). There were 74 non-verified child maltreatment fatalities where the official manner of death was undetermined.

Table 3: Official Manner of Death (from death certificate) by Maltreatment Verification Status

Official Manner of Death	Child Maltreatment Death	
	Verified n=79	Non-Verified n=270
Natural	3	76
Accident	48	108
Suicide	1	6
Homicide	25	2
Undetermined	2	74
Pending	0	0
Unknown	0	4

Table 4 identifies three specific primary causes of death for maltreatment cases that account for 74.7% of known verified child maltreatment fatalities: deaths by drowning (39.2%), trauma/wounds caused by a weapon (17.7%), and asphyxia (17.7%). These are the primary cause of death categories throughout this report.

When the number (n=25) of homicides of children that were verified child maltreatment deaths are cross-referenced against primary cause of death categories, 13 (52%) resulted from weapons, 4 involved asphyxia, 2 involved drowning, 1 involved fire/burns, 1 involved poisoning, 2 were identified with “other” causes. Information on manner of death was missing from the committee report on 2 homicide deaths. The 2 homicide deaths for non-verified child maltreatment cases reviewed involved weapons. In these 2 cases, the person responsible (i.e. that caused the death/homicide) was denoted as a sibling that was not a caregiver or supervisor. Subsequently, the homicide was not classified/verified as a maltreatment death.

Table 5 displays counts of deaths resulting from medical causes. There were 3 verified maltreatment deaths due to medical neglect.

Table 4: Itemization of Specific Cause of Death for External Injuries by Child Maltreatment Verification Status		
Specific External Injury Cause of Death	Child Maltreatment Death	
	Verified n=72	Non-Verified n=135
Weapons	14	5
Asphyxia	14	66
Sleep-related	7	58
Not sleep-related	7	8
Drowning	31	42
Motor Vehicle	4	4
Poisoning, Overdose, Intoxication	3	2
Animal Bite/Attack	0	0
Fire, Burn, Electrocution	1	1
Exposure	1	1
Undetermined	0	4
Other	4	4
Fall/Crush	0	5
Asthma	0	0
Unknown	0	1

Table 5: Itemization of Specific Medical Cause of Death by Child Maltreatment Verification Status		
Specific Medical Cause of Death	Child Maltreatment Death	
	Verified n=2	Non-Verified n=68
Cancer	0	0
Cardiovascular	0	4
Congenital Anomaly	0	12
HIV/AIDS	0	0
Influenza	0	1
Low Birth Weight	0	0
Malnutrition	0	0
Dehydration	0	0
Neurological/Seizure Disorder	0	5
Pneumonia	1	8
Prematurity	1	9
SIDS	0	3
Other Infection	0	10
Other Perinatal	0	0
Other Medical	0	15
Undetermined	0	1
Unknown	0	0

Location of Child Deaths

Please note that in this report, the word "county" refers to the county where the incident took place, not necessarily the county where the death occurred or the county of a child's residence. From a prevention standpoint, the use of the incident county provides more meaningful data regarding the death event. For the top three primary causes of death regardless of verification status:

- 50.7% of all drownings occurred in seven counties: Broward, Duval, Hillsborough, Lee, Orange, Polk, and Volusia.
- 57.5% of all asphyxia deaths occurred in seven counties: Brevard, Duval, Hillsborough, Orange, Pinellas, Polk, and Volusia.
- 78.94% of weapons deaths occurred in five counties: Duval, Orange, Pasco, Pinellas, Polk.

See Appendix G for additional information on location of child deaths.

Drowning Death Incident Information

For drowning deaths, local committees collect information on the details associated with the deaths. Tables 6 and 7 identify details of the location of drowning deaths and barriers in place.

Table 6: Drowning Location by Child Maltreatment Verification Status

Drowning Location	Child Maltreatment Death	
	Drowning n=73	
	Verified (n=31)	Non-Verified (n=42)
Open Water	6	7
Pool/Hot Tub/Spa	19	32
Bathtub	5	1
Bucket	0	1
Well/Cistern/Septic	0	0
Toilet	1	1
Other	0	0

Table 7: Barriers in Place Where Drowning Took Place by Child Maltreatment Verification Status (Duplicate Counts if Multiple Barriers)

Barriers in Place	Child Maltreatment Death	
	Drowning n=73	
	Verified (n=31)	Non-Verified (n=42)
None	5	11
Fence	6	6
Gate	4	7
Door	15	16
Alarm	2	1
Cover	0	0
Unknown	1	6

Among the 31 verified maltreatment drowning deaths:

- 25 cases had data on the child's ability to swim, only 2 (8%) of the 25 children knew how to swim
- 19 (61.3%) occurred in pools, hot tubs, or spas
- 5 (16.1%) drowning cases had no barriers (alarms, gates, etc.) to bodies of water
- 25 (80.6%) cases had barriers in place (some cases had more than 1 barrier)

Among the 42 non-verified maltreatment drowning deaths:

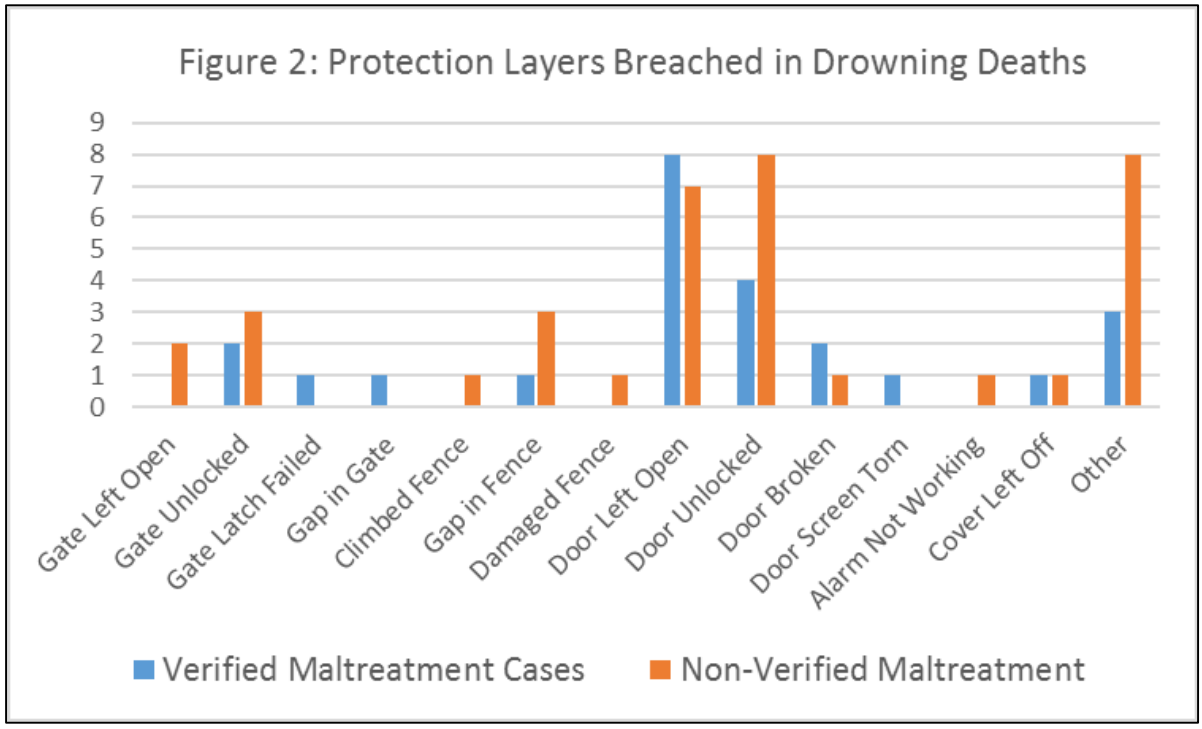
- 35 (or 100% of 35 cases with data on child's ability to swim) did not know how to swim
- 32 (76.2%) occurred in pools, hot tubs, or spas
- 7 (16.6%) cases occurred in open water
- 11 (26.2%) cases had no barriers (alarms, gates, etc.) to bodies of water

Where information was available, data elements were collected on the location of the child *before* drowning, activity of child before drowning, and drowning location. Among verified maltreatment deaths:

- 14 (45.2%) were located in the home prior to drowning
- 7 (22.6%) were in the water prior to drowning

All but two (93.5%) of the children whose death was verified as maltreatment and 100% of children whose death was not verified as maltreatment did not know how to swim. Among verified maltreatment deaths, 19 of 31 (61.3%) of the children were playing, four were sleeping and two were bathing before drowning. Among non-verified maltreatment deaths 33 of 42 (80.5%) were playing prior to drowning. For additional detail, reference tables G-4, G-5, and G-6 in Appendix G.

Since protective barriers were in place for the majority of bodies of water (predominately pools, hot tubs, and spas) where children drowned, information was sought regarding the protective layers that were breached. Where data were available (see Figure 2 below), the most prevalent breach for verified maltreatment drowning deaths included doors being left open (n=8), doors unlocked (n=4), and "other" breaches (n=3). Among non-verified maltreatment drowning deaths, the most prevalent breach included unlocked doors (n=8), "other" breaches (n=8), doors left open (n=7), gates unlocked (n=3), and gaps in fences (n=3). With respect to "other" breaches, local CADR committees identified specific persons (typically adults and/or caretakers) whose actions may have resulted in a barrier breach for the child.



For additional findings on these data elements, see Appendix G.

Asphyxia Death Incident Information

Asphyxia is the deprivation of oxygen that can be due to suffocation or strangulation. Among year 2015 CADR cases thus far reviewed, there were 80 deaths due to asphyxia. As noted in Table 4, 68 of these deaths (8 among verified maltreatment deaths and 60 among non-verified maltreatment deaths) were classified as sleep related. It is important to note that the cause of a sleep-related death may not be able to be determined after investigation and, therefore, may be classified as Sudden Infant Death Syndrome (SIDS) or death from an unknown or undetermined cause.

When available, local CADR committees collect information on risk and protective factors that pertain to sleep-related deaths. For asphyxia deaths that were sleep-related, Tables 8 and 9 provide overviews of some important factors of safe sleep placement and environments among reviewed cases.

Table 8 provides information related to sleep placement position **among cases that were classified as sleep-related asphyxia deaths**: a child's usual sleep placement position, the sleep position a child was placed in **before** being found to be non-responsive or deceased, and the sleep position a child was in when found non-responsive or deceased. The positions of sleep/sleep placement are: On Back, On Stomach, On Side, and Unknown.

Table 8: Sleep Positions Among Sleep-Related Asphyxia Deaths

Position	Verified n=8			Non-Verified n=60		
	Usual n=8	Put to Sleep n=8	Found n=8	Usual n=60	Put to Sleep n=60	Found n=60
On Back	4	4	1	29	27	11
On Stomach	0	1	4	10	18	29
On Side	0	1	2	3	5	12
Unknown	4	2	1	18	10	8

- On Back was the usual placement position for approximately 50% (4 of 8) verified and 48% (29 of 60) non-verified cases
- On Stomach or On Side was the reported sleep position when the child was found non-responsive or deceased in 75% verified (n=6) and 68% non-verified (n=41) cases

Table 9 denotes the incident sleep place for sleep-related asphyxia deaths. Here, 62.5% of verified maltreatment deaths and 60% of non-verified child maltreatment deaths occurred in an adult bed for all reviewed sleep-related asphyxia deaths. These statistics reinforce established concerns from extensive research regarding the risks of bed-sharing of adults with infants and toddlers.

Table 9: Incident Sleep Place for Sleep-Related Asphyxia Deaths

Incident Sleep Place	Verified n=8	Non-Verified n=60	Total n=68
Adult Bed	5 (62.5%)	36 (60%)	41 (60%)
Couch	1 (12.5%)	6 (10%)	7 (10%)
Bassinette	0 (0%)	5 (8.3%)	5 (7.4%)
Playpen	0 (0%)	5 (8.3%)	5 (7.4%)
Chair	1 (12.5%)	2 (3.3%)	3 (4.4%)
Crib	0 (0%)	3 (5%)	3 (4.4%)
Other	0 (0%)	3 (5%)	3 (4.4%)
Futon	1 (12.5%)	0 (0%)	1 (1.5%)
Floor	0 (0%)	0 (0%)	0 (0%)
Total	8 (100%)	60 (100%)	68 (100%)

Case reviews collected information on bed-sharing and objects in the sleep environment. Twenty-two persons (17 adults and 5 children) were found to have unintentionally obstructed airways of children who died from sleep-related asphyxia. Bedding (i.e., pillows, mattresses, comforters/quilts, sheets/thin blankets) was identified to have blocked a child's airway in 53 sleep-related asphyxia cases. See Table G-7 in Appendix G for additional data on this topic.

Weapon Related Death Incident Information

The death review process collects a variety of information related to weapon-related deaths, including information related to the type of weapon, firearms used (if applicable), and the person handling the weapon related to the child fatality. Note that fatalities associated with weapons include a wide range of weapons from firearms to "body parts," indicating **physical abuse**. This intentional bodily infliction of harm is captured in this category and remains a primary concern.

Among the **verified** maltreatment weapon deaths (n=14):

- 4 (28.6%) weapons used were firearms. Among these firearm deaths:
  - 2 of the firearms were handguns and 2 were assault rifles.
  - All of the owners (100%) of firearms used were owned by males.
- 4 (28.6%) weapons were "body parts" (indicating physical abuse).
- 2 weapons were blunt instruments and 1 was a sharp instrument.
- Of the remaining verified weapons deaths, 2 were listed as "other" and 1 was unknown.

Among the **non-verified** maltreatment weapon deaths (n=5):

- 4 weapons used were firearms (80.0%)
- 1 weapon was a sharp instrument (20.0%)

For detailed information for this category, see Appendix G.

CHILD CHARACTERISTICS

The following section highlights analyses associated with select child characteristics.

Age of Child

Regardless of verification status, children under age five had the highest risk for all forms of death. As shown in Table 10, the overwhelming majority of children dying from asphyxia were less than one year old:

- 71% of asphyxia deaths verified as child maltreatment involved children under the age of 1.
- 91% of asphyxia deaths not verified as maltreatment involved children under the age of 1.

Although the majority of children who died from a weapon were four years of age or younger (71% for verified maltreatment cases), all weapon deaths among non-verified maltreatment deaths were with children 6 years of age and older.

Among drowning deaths, 64% of verified maltreatment deaths were children 3 years of age and younger, whereas 79% of non-verified drowning deaths were 3 years of age and younger.

Table 10: Age of Children by Maltreatment Verification Status and Primary Cause of Death								
Age	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
< 1	6%	71%	29%	44%	7%	91%	0%	55%
1	29%	7%	21%	0%	45%	3%	0%	14%
2	16%	0%	14%	25%	17%	0%	0%	6%
3	13%	0%	0%	6%	10%	0%	0%	3%
4	13%	7%	7%	6%	10%	0%	0%	4%
5	10%	0%	0%	6%	0%	0%	0%	1%
6-10	10%	7%	14%	13%	12%	2%	20%	7%
11-15	0%	7%	14%	0%	0%	3%	60%	6%
16+	3%	0%	0%	0%	0%	2%	20%	2%

Figure 3a: Verified Maltreatment Drowning Deaths by Age of Child (n=31)

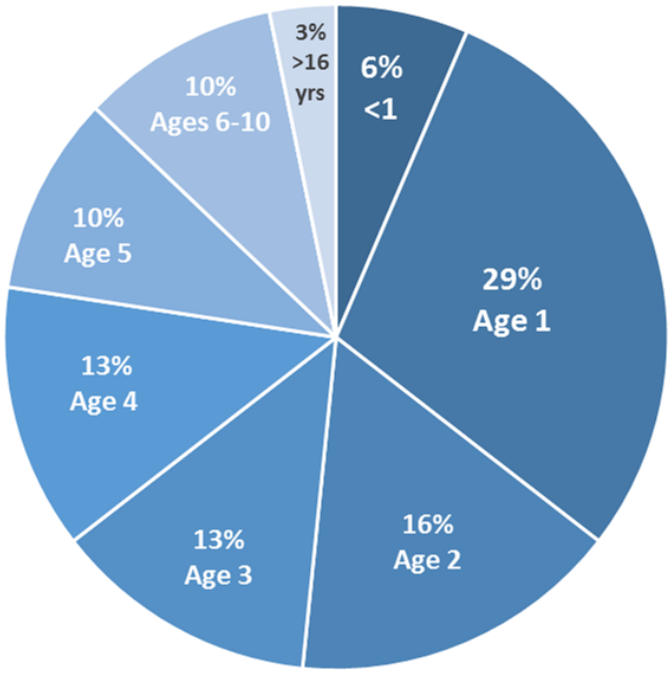


Figure 3b: Verified Maltreatment Asphyxia Deaths by Age of Child (n=14)

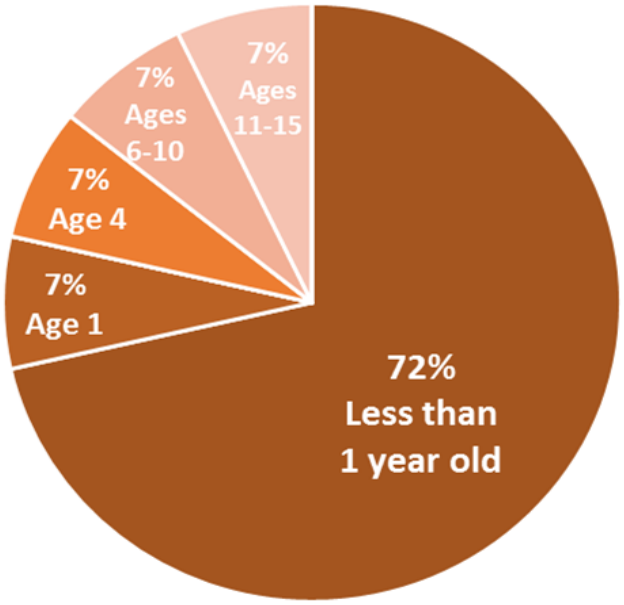
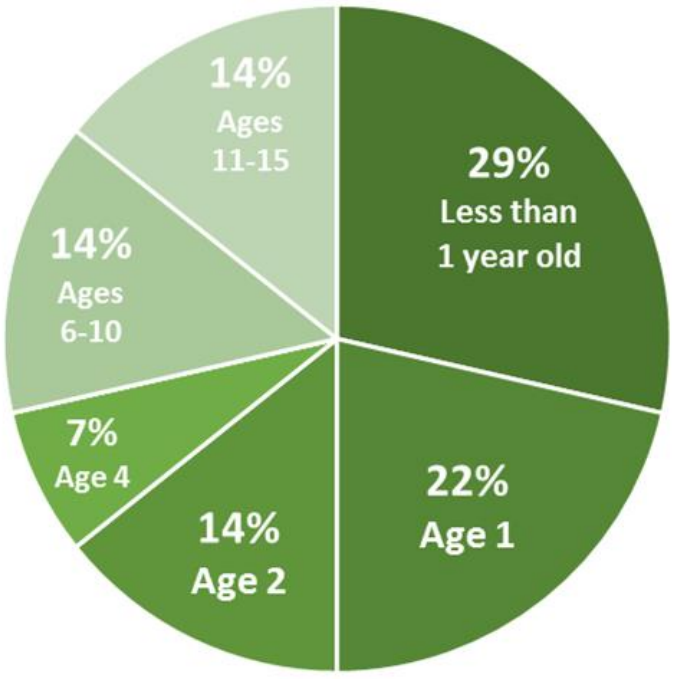


Figure 3c: Verified Maltreatment Weapon Deaths by Age of Child (n=14)



Race of Child and Hispanic or Latino Origin

Child death case reviews result in the collection of data on race and ethnicity as they relate to child maltreatment fatalities. As seen in Table 11, the majority of children within the review sample were identified as white or black.

Ethnicity of the child could also be identified separate from race. Of all **verified** maltreatment fatalities, those children identified to be of **Hispanic or Latino** origin represented:

- 26% of drowning deaths
- 20% of asphyxia deaths
- 21% of weapon deaths
- 13% of other deaths

Table 11: Race and Ethnicity (Hispanic/Latino Origin) of Children by Primary Cause of Death and Maltreatment Verification Status

Race	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
Black	39%	43%	36%	50%	33%	47%	40%	41%
White	55%	57%	57%	56%	57%	55%	60%	59%
Other	3%	0%	7%	0%	10%	0%	0%	<1%
Hispanic or Latino Origin								
Hispanic or Latino	26%	20%	21%	13%	5%	11%	0%	20%

Please note that column percentage totals may exceed 100% as children can be identified as bi- or multi-racial/ethnic.

Sex of Child

Males are disproportionately represented among child fatalities across all primary causes of death for non-verified child maltreatment deaths and for verified drowning and asphyxia maltreatment deaths, as shown in Table 12.

Table 12: Sex of Children by Maltreatment Verification Status and Primary Cause of Death

Child Sex	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
Female	23%	43%	57%	56%	33%	39%	0%	39%
Male	77%	57%	43%	44%	67%	61%	100%	61%

Type of Residence and New Residence

The overwhelming majority (81.7%) of all children who are the subject of this report (n=349) resided in their parental home. In 6 verified and 25 non-verified cases, children lived with relatives. In total, 4 children resided in licensed foster homes (1 verified, 3 non-verified) and 6 resided in a relative foster home (4 verified, 2 non-verified). Statewide information on whether the child's residence was a new residence (occupied within the 30 days prior to the incident) was reportedly known for 262 cases for which only 37 (14.1%) of the residences were considered new residences. Among these 37 cases, 10 were associated with verified maltreatment fatalities.

Is Child From Multiple Birth?

Data on multiple births apply only to those deaths for which the child was under the age of one year. Statewide, only 13 cases (11 non-verified and 2 verified maltreatment cases) were identified to be from multiple births.

Child Problems in School?

Given the age of children, this question was deemed not applicable for 299 children. Among applicable children, 12 were identified as having a school problem which were identified as either academic (n=7), truancy (n=1), and behavioral (n=4).

Disability or Chronic Illness of Child

Statewide, 59 of 349 children (16.9%) were identified as having a disability or chronic illness (4 verified and 55 non-verified maltreatment deaths). Among the 59 children identified to have a disability or chronic illness, where the type of disability or illness was classified*:

- 40 had physical disabilities
- 8 had cognitive/intellectual disabilities
- 21 had sensory disabilities
- 7 had illnesses

** Note: Some children had multiple disabilities.*

Child's Mental Health

Information was collected regarding whether a deceased child had been receiving "current" mental health services, if a child had received mental health services in the past, if a child was on medications for mental health issues/illnesses, and if there were issues that prevented a child from receiving mental health services. For the majority of cases reviewed, these inquiries were not applicable due to the age of the child. For the valid responses received (17), the following was identified:

- 8 children had received prior mental health services (2 were verified and 6 were non-verified cases)
- 9 children were identified as currently on medications for mental health issues (2 of the 9 were verified maltreatment deaths)
- No children were identified to have been prevented from receiving needed mental health services

Child's History of Substance Abuse

For the majority of child fatalities reviewed (82.2%), questions related to the child's history of substance use and abuse were deemed not applicable. Responses to child substance abuse questions were left blank for 5 cases and identified as unknown for 4 cases. Among the remaining 53 cases, there were no children identified to have had a history of substance abuse.

Child's History as Victim of Child Maltreatment

Information related to the child's history of child maltreatment was known for 281 cases, and unknown or not reported for 68 cases. Among the 281 cases for which this history was reported, 72 children (26%) had a known history of child maltreatment. Of these 72 children with a known history of maltreatment:

- 66.6% were classified as non-verified.
- 33.3% were verified as maltreatment deaths.

The distribution (using actual counts and percentage) of known past maltreatment incidents across maltreatment verification status and primary cause of death is shown in Appendix G.

DCF Case Status at Time of Death and Past Placement History for Child and Siblings

Among the cases reviewed, there were 33 cases known and reported by the local committees to have been open child protective services cases at the time of the child death. Of these 33 cases, 12 (36.4%) of these child deaths were classified as verified maltreatment deaths and 21 (63.6%) were identified as non-verified deaths.

Among cases reviewed, there were 27 cases known and reported by the local committees to have been placed outside the home at any time prior to the death (not necessarily at the time of the death). Of these 27 cases, 11 (40.7%) of these child deaths were classified as verified maltreatment deaths and 16 (59.3%) were identified as non-verified deaths. Among the 11 verified cases, seven had in the past been placed by DCF in relative care placements, one was in a group home, and three were reported to have been in out of home placements in the past that were not DCF placements. These last three placements appear to be out of home residences/placements for select child victims that were not the result of any Florida DCF protective orders/actions. For example, one youth who committed suicide had been in a substance abuse facility in the past; information on the specific reported placements of the remaining two verified cases is not known.

Among cases reviewed, there were 44 cases known and reported by the local committees where siblings were placed outside of the home prior to the child's death. Of these 44 cases, 13 (29.5%) of these child deaths were classified as verified maltreatment deaths and 31 (70.5%) were identified as non-verified deaths. Among the 13 verified maltreatment deaths, one case involved a sibling removal in 2005, and 6 cases involved siblings removed between 2009 and 2011. Three cases involved sibling removals between 2012 and 2013. For one case, the siblings were currently in a relative placement when one died; another case involved the removal of the siblings at the time of an incident that eventually led to a child's death months later. Finally, in one case, the siblings of a child were removed in the past from another parent/caregiver that was not the parent of the child that died.

CAREGIVER, SUPERVISOR, AND PERSON(S) RESPONSIBLE CHARACTERISTICS

During case reviews, information is collected on the child's caregivers, the supervisor of the child at the time of the incident leading to the child's death, and for verified child maltreatment deaths, the person(s) responsible for the child's death. Caregivers are identified as the child's "primary caregivers" regardless of their involvement in the child's death. Opportunities are provided for the local committees to collect information on up to two primary caregivers. The supervisor of the child is the primary person responsible for supervising the child at the time of the death incident. This person may or may not be one of the primary caregivers. Finally, for verified child maltreatment deaths, there is a classification of the person(s) responsible for action(s) that caused and/or contributed to the child's death. It is important to note that person(s) may be represented more than once and in various combinations across these three classifications.

Number of Caregivers Present

At least one primary caregiver was identified for all child fatality cases. See Appendix G, which summarizes the percentage of child fatality cases where one or two caregivers were identified.

Average Age of Caregivers, Supervisors, and Person(s) Responsible for Death

The average age of all caregivers, supervisors, and person(s) responsible across all primary causes of death ranges from a low of 27.0 years (for persons(s) responsible for verified weapon maltreatment deaths) to a high of 50.0 years (for persons responsible for non-verified weapon maltreatment deaths) with the average age in the late twenties and early thirties for most other categories. See Appendix G for average ages of caregivers, supervisors, and person(s) responsible for child deaths.

Gender of Caregivers, Supervisors, and Person(s) Responsible for Death

Females were the majority caregivers for children across all categories of death for verified and non-verified maltreatment deaths. The majority supervisors of children for drowning, asphyxia, and other death cases were females. Males were the majority of the supervisors in verified and non-verified weapon cases, and were the majority of person(s) responsible in verified weapon cases.

Note that the Case Report Form does not collect data on relationship or marital status, so head of household status is unknown. The state committee recommends adding this data element to the Case Report Form for Florida cases. By collecting these data, we will be better able to understand how marital status and household living situations may impact child maltreatment.

Substance Abuse History of Caregivers, Supervisors, and Person(s) Responsible for Child's Death

Local committees were asked to identify, using information available, whether any caregivers, supervisors, and/or person(s) responsible had an identified substance abuse history. Note that "history" of substance abuse does not necessarily indicate that the individual was using substances during the death incident.

For verified child maltreatment cases:

- 36% of caregivers were known to have a substance abuse history
- 38% of supervisors were known to have a substance abuse history
- 51% of person(s) responsible were known to have a substance abuse history

See Appendix G for detailed information related to substance abuse history of all caregivers, supervisors and person(s) responsible.

Mental Health History of Caregivers, Supervisors, and Person(s) Responsible for Child's Death

Collection of data regarding mental health history can be challenging for a number of reasons. There are likely differences in how this data element may be interpreted and collected by each committee (i.e., requiring a formal diagnosis vs. collateral information). In addition, individuals with a past diagnosis of mental illness may be reluctant to share this information. As a result, mental health history is often under-reported, leading to case sample sizes that are too small to make valid conclusions. For example, among all caregivers (first and second) identified across all child fatality cases reviewed, information on the history of chronic illness (including mental health history) is unknown for 95 caregivers (denoted in tables). However, there were an additional 101 caregivers (7 first and 94 second) for which data (not reflected in tables) were missing on this question (i.e. data element). These figures highlight the need for better collection of information regarding mental health history of family members associated with a child fatality case.

When information was available, committees collected mental health history data on both verified and non-verified maltreatment deaths. Of those cases where the presence of disability or chronic illness was identified, verified maltreatment deaths resulting from drowning show the following:

- 33% of caregivers were known to have a mental health history (2 out of 6 caregivers)
- 43% of person(s) responsible were known to have a mental health history (3 of 7 persons responsible)

Mental health histories were more prevalent in asphyxia cases, particularly those verified as maltreatment. For verified maltreatment deaths resulting from asphyxia (of those cases where the presence of disability or chronic illness was identified), 100% of caregivers (4 of 4), 100% of supervisors (3 of 3), and 100% of person(s) responsible (4 of 4) were known to have mental health issues.

For verified maltreatment deaths resulting from weapons:

- 25% of caregivers were known to have a mental health history (1 out of 4 caregivers)
- 100% of supervisors were known to have a mental health history (2 out of 2 supervisors)
- 25% of person(s) responsible were known to have a mental health history (1 out of 4)

As noted earlier, given the small number of those identified with mental health histories and the number of 2015 cases still to be reviewed, these findings should be considered tentative estimates.

Disability or Chronic Illness Occurrence of Caregivers, Supervisors, and Person(s) Responsible for Death

The Case Report Form collects information on the occurrence of disability or chronic illness among the categories identified above, however, note that the presence of such a disability or illness does not mean that the condition was related to the death incident. The vast majority of caregivers, supervisors, and person(s) responsible were noted not to have a disability at the time of a child's death. For more information on disability or chronic illness data element, see Appendix G.

Additional Characteristics of Caregivers, Supervisors, and Person(s) Responsible

Located in Appendix G is detailed information on the following:

- Employment of caregivers
- Education level of caregivers
- English spoken by caregivers, supervisors, and person(s) responsible
- Active military duty of caregivers, supervisors, and person(s) responsible
- Caregiver receipt of social services

Past History as Victim of Child Maltreatment among Caregivers, Supervisors, and Person(s) Responsible for Death

Local committees were asked to identify from available sources of information whether caregivers, supervisors, and person(s) responsible for the death of a child were past victims of child maltreatment. Local committees reported on 480 caregivers identified (up to two caregivers could be identified per case) for the 349 cases reviewed for which information on past history as a victim of child maltreatment was unknown for 89 (18.5%) caregivers. See Appendix G for a breakdown of the proportion of caregivers, supervisors, and person(s) responsible with a history of maltreatment as children, where the majority of caregivers did not have a history as a victim.

Past History as Perpetrator of Child Maltreatment among Caregivers, Supervisors, and Person(s) Responsible for Death

Local committees were asked to identify whether caregivers, supervisors, and person(s) responsible for a child's death have a history as a perpetrator of child maltreatment. For verified cases, the following had a history as a perpetrator: caregivers (35%), supervisors (27%) and person(s) responsible (41%).

Past History of Intimate Partner Violence (as Victim and Perpetrator) among Caregivers, Supervisors, and Person(s) Responsible

When available, local committees collected information about caregivers' history with intimate partner violence as a victim and/or perpetrator. It is unclear whether the caregivers were victims or perpetrators near the time of the child's death or if they were labeled as victims or perpetrators because of historical information gathered by local teams.

Appendix G provides more detailed information regarding the history of intimate partner violence (as victim and perpetrator) among caregivers, supervisors, and person(s) responsible.

National research suggests that exposure to intimate partner violence as a child, particularly for male children, is a risk factor for perpetrating violence on one's family members as an adult. However, many children who grow up in abusive homes will never abuse their family members and are often outspoken in their efforts to prevent such violence. It is recommended that supplemental analyses are conducted in future reports regarding the contextual factors in these cases in order to gain additional insight that will help to prevent such deaths in the future.

The State CADR Committee intends to collect additional information from local teams for future reports regarding contextual factors when intimate partner violence is present in child death cases.

Past Criminal History of Caregivers, Supervisors, and Person(s) Responsible for Death

Among caregivers associated with verified maltreatment deaths, 37.2% (51 of 137) had committed a criminal offense in the past. Among those with a criminal history, those with drug offenses were represented from a low of 28% for caregivers associated with verified drowning deaths to a high of 59% of those caregivers associated with asphyxia deaths. The highest proportion of person(s) responsible (for verified maltreatment cases) with a criminal history were those affiliated with deaths caused by asphyxia (71%), other causes of deaths (44%), weapons deaths (38%), followed by drowning deaths (30%).

SECTION FOUR: FUTURE ANALYTIC PLANS

One overarching objective of epidemiological analyses is to connect findings of the CADR data to inform prevention and interventions for larger general populations, which, for the State Committee purposes, are children who are neglected and abused. However, analyses and assessments can also greatly inform prevention and interventions for all children who are exposed to child safety risks. There is a variety of ways to conduct epidemiological studies; the following will outline a few of the methods that will be used in forthcoming analytical works.

Currently, data collected for the case reviews are similar to cross sectional surveys, where information is gathered that is related to causes of death events and characteristics associated with persons, time, and environments connected with the deceased children. Some temporal (time sequence) and exposure-outcome relationships can be explored with Florida CADR data, but the data collected may not provide any or may provide inconsistent information on other events, environments and circumstances that may have also influenced maltreatment outcomes and/or the risks of child death. As has been done within this report, findings of descriptive analyses can be used to contrast and compare with findings of other reputable research about child maltreatment and deaths that result from child maltreatment.

The primary comparisons within this report have been between those child fatalities verified versus non-verified to be a result of child maltreatment. Future comparisons can gauge and test factors that have a predictive influence on whether the child fatality is a result of maltreatment or not. However, the conclusions from such tests relate only to the population of cases called to the Florida Abuse Hotline.

Other research/study designs may better inform prevention initiatives in the future. For example, using cohort study designs, children can be "followed" forward or back in time to obtain information on exposures and outcomes that occurred during a time-period. With this type of study design, a variety of exposures can be assessed and temporal sequence of risk/protective exposures and outcomes is easier to determine. An example of a desired cohort study design is a birth cohort analysis, where maternal, paternal, and infant factors before, during, and shortly after delivery of a child can be obtained; and outcomes can be compared between infants (children < 1 year old) who are not exposed to maltreatment or who are exposed to maltreatment. To obtain pertinent information on children after the first year of life, it will be important to link to data that can provide a true picture of events occurring in a child's life beyond the first year (i.e. education; medical and mental health assessments and interventions; family socioeconomic status; neighborhood conditions). DCF is currently engaged in efforts that utilize predictive analytics tools and techniques with historical and cohort data from multiple sources (including DCF FSFN and DOH vital statistics data) whose results (when published) may be of assistance in furthering the interpretation of findings generated from the local CADR committee reviews of child fatality cases. Once the DCF study is complete, a review of the study's findings in concert with findings generated from CADR committee reviews may be warranted by the State CADR Committee as a means of developing collaborative recommendations for prevention initiatives.

In addition to the above considerations, the State CADR Committee has made the following recommendations for future analyses:

- Supplemental analyses (on select data elements) including but not limited to multi-year analysis on 2015 fatalities when the remaining 125 child fatality cases are closed and reviewed by local committees.
- Examination of select differences in cases verified versus non-verified as child maltreatment for sleep-related asphyxia and drowning fatalities.

- Consider adding relationship or marital status as a data element, so head of household status (among caregivers) is known and used in analyses in an effort to better understand how marital status and household living situations may impact child maltreatment.
- Explore the availability of data from local committee reviews that can aid with supplemental analyses regarding the contextual factors associated with cases involving a history of intimate partner violence.

To inform a public health approach to child maltreatment deaths, connections between maltreatment outcomes and prevention/intervention initiatives, policies, and practices need to be assessed to determine evidence-based pathways that could lead to eliminating child maltreatment deaths. For future analyses of intervention and prevention impacts, studies could assess and compare outcomes of children participating in pilot programs, or when community-wide or statewide population interventions are implemented. Once again, population data (beyond that available to the State CADR Committee) would be needed to provide the necessary information to make valid assessments on the impact of implemented preventions and interventions on child maltreatment outcomes.

SECTION FIVE: THE CHANGING LANDSCAPE OF FLORIDA'S CHILD WELFARE SYSTEM

Florida's statewide perspective regarding the reduction of child fatalities has evolved over time. Through continuous analysis of data and timely reviews of the latest research, our child welfare system shifts, adapts, and continually seeks to improve our collective capacity to meet the ever-changing needs of a diverse population.

IMPROVING PRACTICE TO ENSURE CHILD SAFETY

DCF has adopted a practice model that combines a safety assessment and actuary risk assessment to better analyze the family condition and guide appropriate interventions. The practice requirements include: completing an immediate present danger assessment; developing safety plans upon the identification of a danger threat; collecting information in the Family Functioning Assessment (which includes six sections of collection around maltreatment, circumstances around maltreatment, adult functioning, child functioning, parenting, and parenting discipline); and assessing parental protective capacities to determine child safety and the need for service intervention. Assessment information is used to make the safety determination, as well as to determine risk of future maltreatment (using an actuarial tool). Note that both determinations guide the level of intervention. For example, if the child is determined unsafe, the family is provided formal case management services through the Community-Based Care Provider. If the family is determined safe but at high or very high risk for future maltreatment, the family must be referred for Family Support Services. The practice directs investigators to use subject matter experts and multidisciplinary teams to inform assessments and decisions. The model applies to upfront investigations, as well as ongoing services intervention, so the assessment is consistent and aligned throughout involvement with families.

In conjunction with the new practice model, DCF has taken significant steps to lead a statewide collaborative effort to support and enhance the integration of behavioral health services within the child welfare system. This initiative seeks to improve the integration of critical substance abuse and mental health services within child welfare systems of care at the community level. The Florida Framework for Child Welfare and Behavioral Health Integration outlines practice expectations and system components indicative of successful integration. Teams of community stakeholders have mobilized at regional and circuit levels to self-assess the level of integration within their own service delivery systems by using the framework. This important work will help improve the processes and partnerships necessary to ensure that appropriate and timely mental health and substance abuse services are provided to those in need of such services.

THE PUBLIC HEALTH PERSPECTIVE: A CALL TO ACTION

Child maltreatment is a serious public health problem. The Administration for Children and Families (ACF) estimates that approximately 700,000 children in the United States are victims of maltreatment each year; approximately 1,600 child deaths occur as a result of maltreatment. Recurring child maltreatment, whether or not it results in fatality, has far-reaching consequences and implications for society as a whole. Research has shown that an increased incidence of adverse childhood experiences strongly correlates with adverse health outcomes later in life. Increased exposure to such experiences not only increases the risk of subsequent substance abuse and mental health problems, but a host of chronic health issues as well, such as cancer, heart disease, diabetes, and chronic obstructive pulmonary disease. The Centers for Disease Control and Prevention (CDC) estimates that the total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States is approximately $124 billion.

Child maltreatment and preventable fatalities are issues that reach well beyond the scope of one agency. Strategies to prevent child maltreatment must be implemented using a multi-level, multi-sector approach.

Public health, social services, health care, education, justice, and even non-traditional partners such as businesses and service organizations need to work together to prevent child maltreatment and its consequences. This collaborative approach ensures consistency of messaging, encourages the pooling of resources, and reduces duplicative efforts.

A comprehensive approach that engages all levels of our social ecology (including societal culture) will positively impact community involvement, relationships among families, and individual behaviors. Effective prevention strategies should focus on modifying policies, practices, and societal norms to create safe, stable, nurturing relationships and environments. The State CADR Committee has and will continue to utilize research and practice recommendations of the CDC pertaining to child maltreatment and violence prevention. Efforts to synthesize CDC recommendations with local prevention initiatives and resources will be a focus of coordinated efforts between the State CADR Committee and local CADR committees in the upcoming year.

THE COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

The Commission to Eliminate Child Abuse and Neglect Fatalities recently released a final report on developing a national strategy to eliminate child abuse and neglect fatalities. The State CADR Committee has begun review and discussion on the Commission's findings and their applicability for Florida. Focus has been on a series of recommendations targeting state and county governments. The State of Florida is engaged in many initiatives and has established efforts in keeping with many recommendations put forth by the Commission. Regardless, the State CADR Committee (as a collaborative partner with other state agencies and initiatives) will review how current and future efforts align with and can be responsive to recommendations put forth by the Commission for state agencies and counties.

SECTION SIX: IMPLEMENTATION OF PREVIOUS RECOMMENDATIONS

FROM ANALYSIS TO ACTION

The introduction of the CADR Cycle framework has prompted a renewed effort to ensure that data collection and analyses ultimately result in meaningful action. CADR data and corresponding recommendations continue to play a pivotal role in the shaping of prevention strategies at both state and local levels. From a CADR system perspective, the continuous evaluation of internal processes and ongoing assessment of the needs of stakeholders have resulted in a number of system improvements.

PREVENTION ACTIVITIES AT THE LOCAL LEVEL

Although local committees were newly formed this year to align with judicial circuits (see map, page 10), many carried the momentum of previously established community-based initiatives informed by previous years' CADR data and recommendations. Other local circuit-based committees engaged in new activities in response to patterns identified in 2015 case review data as they surfaced throughout the reporting period. In most circuits, local committees successfully leveraged previous CADR recommendations in a meaningful way.

Several local circuit-based committees have become especially adept at community collaboration, particularly in those areas where many agencies, boards, councils, and/or task forces may have similar or overlapping goals. These committees have successfully developed partnerships with other groups within their community, providing a workable venue for sharing information and resources, prioritizing efforts, and aligning prevention messaging to ensure consistency across groups.

Other local circuit-based committees have joined multiple community partners in prevention awareness campaigns and initiatives focused on water safety and/or safe sleep, based on past CADR data and recommendations. A number of these initiatives go beyond basic messaging to provide concrete supports and parent education to high-risk populations within their community.

As a result of committees' identification of potential gaps within local service delivery systems, several circuits took proactive measures to create processes that ensure appropriate mental health and substance abuse services are readily accessible for high priority, at-risk populations.

For detailed examples of local committee prevention activities, see Appendix F.

PREVENTION ACTIVITIES AT THE STATE LEVEL

CADR data findings and recommendations also significantly influence programmatic policies and processes at the state level. CADR findings help determine training needs for statewide staff, inform decisions regarding prioritization of effort, and assist in the development of policies to support and protect the well-being of Florida's children.

DOH leverages CADR data, along with various other data sources, to address social determinants of health (behavioral, social, and environmental factors) that impact child development and health outcomes, with a specific focus on social determinants correlated with health inequities. This knowledge, in turn, informs statewide policy and practice. For example, the Florida Healthy Babies Initiative was launched this calendar year to address disparities in infant mortality. All Florida counties received funding to conduct data analysis on infant mortality and collaborate with multi-disciplinary community partners to create and implement action plans designed to address identified health disparities. As part of the new Healthy Moms and Babies program initiative, the Circle of Parents® program was initiated. Circle of Parents® provides a friendly, support

environment led by parents and other caregivers. It is a place where anyone in a parenting role can openly discuss the successes and challenges of raising children. Another project involves a contract with Florida A & M University to conduct focus groups statewide to evaluate the acceptance of the safe sleep concept as it relates to the use of "baby boxes." The box serves primarily as a safe, comfortable place for infants to sleep, similar to a bassinet. An ideal spot for the box is on a stable surface right next to the parents' bed. Some parents prefer keeping their box in the living room or dining area so that their baby can relax nearby while the parents are busy with chores, meals, and so on.

Several recommendations within the 2015 Annual CADR Report were operationalized by DCF, including the development and implementation of training on motivational interviewing, designed to enhance the supervisory skillsets of child protection investigator supervisors and case manager supervisors. The Office of Child Welfare recognized the need to incorporate motivational interviewing into the pre-service training that all direct service staff complete as part of the child welfare professional certification process; efforts to incorporate this material are currently underway. DCF also continues to maintain the Child Fatality Prevention Website – a publicly accessible website containing information on all child fatalities reported to the Florida Abuse Hotline alleged to be a result of abuse or neglect. The website serves as a portal for readily accessible child fatality data, which are sortable by county, child's age, causal factor, and prior DCF involvement. The website features seven years of historical data and can be used by local committees and other stakeholders to identify community-specific trends.

Prominent social service agencies with a statewide presence, such as the Ounce of Prevention Fund of Florida, incorporate CADR data and recommendations into trainings for home visitors and other staff working directly with families. CADR findings shape programmatic content to address potential hazards such as unsafe sleep practices. Findings also inform the strategic allocation of resources to ensure that prevention activities are aimed at those issues with the highest potential impact on child safety and well-being. CADR findings also inform the direction and content of statewide campaigns, such as the Prevent Child Abuse Florida campaign.

PROCESS IMPROVEMENTS WITHIN THE CADR SYSTEM

As the landscape of child welfare evolves over time, CADR processes adapt accordingly within Florida's dynamic multi-disciplinary system to collectively ensure the safety and well-being of children across the state. During this calendar year, several improvements have been made within the CADR system to streamline processes and increase the effectiveness of the fatality review process. Opportunities to improve are most often identified as a result of input from those actively working within the system, such as circuit committee chairs, CADR health officers, and DCF Child Fatality Prevention Specialists. Feedback and input from these key stakeholders resulted in improvements such as the new case file transfer process (described earlier in this report).

Upon the establishment of new circuit-based committees, needs assessment surveys were sent to key stakeholders to better determine the needs of committee chairs and CADR health officers and to identify potential barriers to meeting committee goals. The results of these surveys informed the provision of technical assistance to newly formed committees and training content presented during monthly circuit conference calls. The incorporation of web-based conferencing greatly improved participant engagement and the effectiveness of monthly calls, which now allow for the exchange of both audio and visual information. Expanding call participation to include additional stakeholders improved communication and encouraged collective problem solving among those with differing roles within the system.

SECTION SEVEN: 2016 PREVENTION RECOMMENDATIONS

MOVING FORWARD: A SOCIAL ECOLOGICAL MODEL FOR CHANGE

As outlined in the Data Section of this report, the top three categories of preventable child fatalities in Florida continue a trend that has persisted over the last several years. These categories include child fatalities that occur as a result of:

- Drowning
- Asphyxiation
- Inflicted Trauma (Weapons)

This year's prevention recommendations are based on an analysis of Florida's CADR findings for 2015 cases reviewed to date, input provided by State and local CADR committees, and a review of literature and the most current research on prevention strategies as outlined by our nation's foremost experts. Research and literature contributing to this year's recommendations include the following:

- *Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities*, developed by the National Center for Injury Prevention and Control with the Centers for Disease Control (CDC)
- *Essentials for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environments*, also developed by the CDC's National Center for Injury Prevention and Control
- *Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, Final Report, 2016,* developed by the Commission to Eliminate Child Abuse and Neglect Fatalities

As reflected within this report, successful strategies to prevent child maltreatment are best implemented using a highly collaborative, comprehensive, multi-level, and multi-sector approach. In order to adequately address each level of intervention, approaches to prevention can be organized using the following framework known as the Social Ecological Model for Change.

This four-level model, as presented by the CDC, serves as a framework for prevention and illustrates the various factors that interact, overlap, and ultimately impact our understanding of societal issues (such as interpersonal violence). The above graphic also reflects the need to act across multiple levels of the model to achieve sustainable change. Societal, community, relationship, and individual levels of social ecology must all be considered during the development of prevention strategies.

The following key prevention strategies and approaches recommended by the CDC cut across all levels of social ecology model and engage a wide range of societal sectors in prevention efforts.

Strategy	Approaches	Lead Sectors
Strengthen economic supports to families	Strengthening household financial security Family-friendly work policies	• Government (Local, State, Federal) • Business/Labor
Change social norms to support parents and positive parenting	Public engagement and education campaigns Legislative approaches to reduce corporal punishment	• Public Health • Government (Local, State, Federal)
Provide quality care and education early in life	Preschool enrichment with family engagement Improved quality of child care through licensing and accreditation	• Social Services • Public Health • Business/Labor • Government (Local, State, Federal)
Enhance parenting skills to promote healthy child development	Early childhood home visitation Parenting skill and family relationship approaches	• Public Health • Social Services • Health Care
Intervene to lessen harms and prevent future risk	Enhanced primary care Behavioral parent training programs Treatment to lessen harms of abuse and neglect exposure Treatment to prevent problem behavior and later involvement in violence	• Public Health • Social Services • Health Care • Justice

** Table adapted from an expanded version outlined in Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities, developed by the by the National Center for Injury Prevention and Control with the Centers for Disease Control (CDC)*

In addition to the above strategies, the state committee makes the following state-specific recommendations, all of which will serve to further prevent the incidence of drowning, unsafe sleep practices, and inflicted trauma:

❖ ***Enhance and Support the Integration of Behavioral Health Services into the Child Welfare System***

Substance use disorders, mental health disorders, and dynamics associated with domestic violence result in profoundly negative impacts on parental capacity and child well-being while greatly increasing the risk of child harm. Readily accessible and appropriate interventions for at-risk families dealing with these issues is a critical step toward ensuring a safe, stable, and nurturing environment for children. Community-based systems of care must take the necessary steps to ensure behavioral health services are comprehensively integrated into the service delivery system to sufficiently meet the needs of their client population. Scope of services should address all levels of need, including prevention, intervention, and treatment services, as well as the provision of ongoing recovery supports to ensure struggling families have the resources needed to bolster resiliency and to attain sustained stability.

Traditional approaches to managing child maltreatment have focused, understandably, on treating its immediate short-term effects and preventing recurrences. Recent studies, however, have demonstrated that more comprehensive, trauma informed interventions are needed to prevent long-term effects extending into adulthood and causing serious morbidity and mortality.

Adverse Childhood Experiences (ACEs) include physical, emotional and sexual abuse; physical and emotional neglect; exposure to domestic violence and substance abuse; loss of or abandonment by a parent; and parental mental health issues. Associations were found with poor academic achievement, poor work performance and health-related poor quality of life. Prevention and early, trauma-informed treatment of children with high ACE scores results in improved health outcomes across the lifespan and a reduction of healthcare costs.

Behavioral health services in the child welfare system should include an assessment of trauma for children exposed to ACEs and appropriate trauma informed interventions to improve short and long-term health outcomes.

- ***Continue to Support Programs that Enhance Parenting Skills***

Children develop within the context of the family; early experiences shape the brain during early childhood. Safe, stable, and nurturing relationships are essential for healthy child development. Evidence suggests that parent coaching and support programs are effective in increasing positive parenting practices, reducing child abuse and neglect, and increasing family stability. In Florida, voluntary in-home parent support programs supplement individual-level and relationship-level interventions by providing parent education, connecting families to needed resources in the community, and promoting the development of protective factors existing within the family and community. These supports lead to improved outcomes for families including reduction and prevention of child abuse and neglect, reduction in risk factors for abuse and neglect, improved parent-child interaction, increased family stability and self-sufficiency, and improved child and maternal health.

- ***Ensure Clear and Consistent Messaging among Agencies During Efforts to Increase Awareness***

Given the wide array of agencies and organizations involved in prevention messaging, it is not surprising that widespread messaging designed to encourage prevention-oriented behaviors may be susceptible to inconsistencies, especially if the conveyed messaging lacks the appropriate context to fully frame a more specific message. For example, a recent policy statement from the American Academy of Pediatrics (AAP) has consistently recommended safe infant sleep practices including supine sleeping, use of firm sleeping surface, room sharing without bed-sharing and avoiding soft bedding. The updated 2016 recommendations include these same risk-avoidance practices and maintain that infants should be placed wholly on their back for every sleeping episode by every caregiver until the child reaches one year of age. Caregivers are encouraged to limit or eliminate infant exposure to smoke, alcohol, and illicit drugs. The recommendations also promote protective practices including breastfeeding, routine immunization, and pacifier use during sleep.

The updated 2016 policy statement also recognizes caregiver fatigue as a risk factor for unsafe sleep related deaths. While underscoring the importance of a firm, separate sleep space for infants, the 2016 policy directs caregivers to return their baby to their own sleep space after calming or feeding in an adult bed. According to the policy statement, “Evidence suggests that it is less hazardous to fall asleep with the infant in the adult bed than on a sofa or armchair, should the parent fall asleep.” Recommendations include strong statements about how to safely calm or feed a baby in bed while tired, including keeping the adult bed free of pillows and bedding and moving baby to a separate sleep space as soon as possible. However, some media coverage of the updated recommendations has included headline statements such as “Stay on the Bed If You're Tired and Feeding Your Baby.” This can be confusing and may be misinterpreted to encourage bed-sharing.

The consistency of Florida’s safe sleep messaging is both a community- and state-level issue as collaboration and communication between agencies must occur so that consistent language can be crafted in a way to

avoid confusing caregivers about the safety of sharing a sleep surface with infants under the age of one. Care must be taken to ensure that all preventive measures outlined in the AAP recommendations are thoroughly and clearly presented to parents, especially if parents express fear that they may fall asleep while feeding their baby. If providers do share the recommendation to feed on an adult bed rather than a couch or armchair, care must be taken to ensure that parents understand how to make the adult bed as safe as possible and that moving the child to a separate sleep space must happen as soon as possible.

❖ ***Encourage Collaborative Partnerships at both the State and Community Levels***

Challenges such as ensuring the consistency of messaging are far more manageable when well-connected interagency and community stakeholder partnerships are established and regularly maintained. Collaborative partnerships are a necessity for system success as they encourage the sharing of data and information by establishing reliable streams of communication between agencies and organizations. These partnerships address the state- and community-level factors that play into the success of collective prevention campaigns, a fact reinforced by recommendations put forth by the Commission to Eliminate Child Abuse and Neglect Fatalities. Collaborative partnerships also encourage the pooling of limited resources and serve to align prevention planning while reducing duplicative efforts.

❖ ***Explore the Value and Utility of Existing Prevention Activities Throughout Florida***

As demonstrated earlier in this report, many existing prevention activities are already underway in various circuits throughout Florida. The state committee recommends that the value and utility of such initiatives and efforts be fully explored. Strategies and approaches that show some level of promise and appear to have positive impacts on prevention efforts should be considered for replication in other areas within the state. Resources including tools, templates, and promising practices can be shared among local committees to further attempt to reduce duplication of effort and encourage consistent messaging throughout the state.

❖ ***Develop Toolkits to Assist in the Planning and Development of Prevention Activities***

As promising practices are identified, readily accessible toolkits should be developed to provide concrete resources, tools, templates, proven processes, and other information that may serve to further additional circuits' efforts to address identified concerns. Various toolkits could be developed to help address specified hot topics, such as Water Safety Awareness, Safe Sleep Initiatives, Bolstering Protective Factors to Increase Parental Capacity, and Tips and Techniques for Fostering Community Collaboration. These toolkits should be developed based on standards and recommendations acknowledged by research, professional literature, and/or existing state and federal agencies.

❖ ***Offer Training and Technical Assistance to Circuits Regarding How to Leverage Data to Inform and Improve Practice***

Training and related technical assistance should incorporate tips and techniques designed to result in the cleaner collection of data through the consistent use of agreed-upon interpretations of data elements. Technical assistance can incorporate information on how to leverage available data tools, such as the DCF Child Fatality Prevention Website, and training on basic data analysis techniques and action planning can be provided to those circuits most interested in delving into their own localized data. All circuits and stakeholders can be provided with guidance regarding how to best leverage the findings of this report to develop sound and effective prevention techniques designed to the meet the specific needs of their areas. This recommendation is, in part, in keeping with the following recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities:

- Enhance local systems' ability to share data to save children's lives and support research and practice
- Leverage opportunities across multiple systems to improve the identification of children and families at earliest signs of risk

SECTION EIGHT: CONCLUSIONS AND NEXT STEPS

In summary, child maltreatment is a critical public health issue with devastating consequences for society as a whole. Efforts to create positive, sustainable change will require a multi-sector approach that sufficiently addresses all levels of the social ecology model, from intervention at the individual level to influencing cultural and societal norms. Overarching prevention strategies at state and local levels can be tailored to address issues clearly identified as chief concerns. Drowning, asphyxia (unsafe sleep), and inflicted trauma continue to be the top three primary causes of preventable deaths in children, and will require well-coordinated efforts that incorporate consistent messaging to address these trends.

To ensure successful outcomes we must adopt evidence-based prevention programs and practices, as we further evaluate new and innovative practices that show promise. We must continue to improve and expand upon appropriate and available data sets to further research child maltreatment in Florida, as we strive to reach beyond the mere collection of data, and ensure that meaningful analysis of the data ultimately leads to strategic action.

We must continue to improve and expand upon appropriate and available data sets to further research child maltreatment in Florida, as we strive to reach our ultimate goal:

To eliminate preventable child fatalities in Florida by better understanding the complexities of child maltreatment and leveraging this evidence-based knowledge to drive current and future prevention strategies.

APPENDICES

ANNUAL REPORT

DECEMBER 2016

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APPENDIX A:

Section 383.402, Florida Statutes

Section 383.402, Florida Statutes

383.402 Child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committees.—

(1) INTENT.—It is the intent of the Legislature to establish a statewide multidisciplinary, multiagency, epidemiological child abuse death assessment and prevention system that consists of state and local review committees. The committees shall review the facts and circumstances of all deaths of children from birth to age 18 which occur in this state and are reported to the central abuse hotline of the Department of Children and Families. The state and local review committees shall work cooperatively. The primary function of the state review committee is to provide direction and leadership for the review system and to analyze data and recommendations from local review committees to identify issues and trends and to recommend statewide action. The primary function of the local review committees is to conduct individual case reviews of deaths, generate information, make recommendations, and implement improvements at the local level. The purpose of the state and local review system is to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.
(b) Whenever possible, develop a communitywide approach to address such causes and contributing factors.
(c) Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse.
(d) Recommend changes in law, rules, and policies at the state and local levels, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.
(e) Implement such recommendations, to the extent possible.

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) Membership.—

1. The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the State Surgeon General, who shall serve as the state committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

a. The Department of Legal Affairs.
b. The Department of Children and Families.
c. The Department of Law Enforcement.

d. The Department of Education.
e. The Florida Prosecuting Attorneys Association, Inc.
f. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

2. In addition, the State Surgeon General shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies listed in subparagraph 1., and ensuring that the committee represents the regional, gender, and ethnic diversity of the state to the greatest extent possible:

a. The Department of Health Statewide Child Protection Team Medical Director.
b. A public health nurse.
c. A mental health professional who treats children or adolescents.
d. An employee of the Department of Children and Families who supervises family services counselors and who has at least 5 years of experience in child protective investigations.
e. The medical director of a child protection team.
f. A member of a child advocacy organization.
g. A social worker who has experience in working with victims and perpetrators of child abuse.
h. A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program.
i. A law enforcement officer who has at least 5 years of experience in children's issues.
j. A representative of the Florida Coalition Against Domestic Violence.
k. A representative from a private provider of programs on preventing child abuse and neglect.
l. A substance abuse treatment professional.

3. The members of the state committee shall be appointed to staggered terms not to exceed 2 years each, as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.

4. Members of the state committee shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) Duties.—The State Child Abuse Death Review Committee shall:

1. Develop a system for collecting data from local committees on deaths that are reported to the central abuse hotline. The system must include a protocol for the uniform collection of data statewide, which must, at a minimum, use the National Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths.

2. Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.

3. Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse. Training must be provided by the Florida Coalition Against Domestic Violence, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise.

4. Develop statewide uniform guidelines, standards, and protocols, including a protocol for standardized data collection and reporting, for local child abuse death review committees and provide training and technical assistance to local committees.

5. Develop statewide uniform guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.

6. Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.

7. Provide consultation on individual cases to local committees upon request.

8. Educate the public regarding the provisions of chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.

9. Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.

10. Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.

(3) LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES.—At the direction of the State Surgeon General, a county or multicounty child abuse death review committee shall be convened and supported by the county health department directors in accordance with the protocols established by the State Child Abuse Death Review Committee.

(a) Membership.—The local death review committees shall include, at a minimum, the following organizations' representatives, appointed by the county health department directors in consultation with those organizations:

1. The state attorney's office.
2. The medical examiner's office.
3. The local Department of Children and Families child protective investigations unit.
4. The Department of Health child protection team.
5. The community-based care lead agency.
6. State, county, or local law enforcement agencies.
7. The school district.

8. A mental health treatment provider.
9. A certified domestic violence center.
10. A substance abuse treatment provider.
11. Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child, shall attend any meetings where the child's case is reviewed. The members of a local committee shall be appointed to 2-year terms and may be reappointed. Members shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) Duties.—Each local child abuse death review committee shall:

1. Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee. The local committee shall complete, to the fullest extent possible, the individual case report in the National Child Death Review Case Reporting System.

2. Submit written reports as required by the state committee. The reports must include:

a. Nonidentifying information from individual cases.

b. Identification of any problems with the data system uncovered through the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.

c. All steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

3. Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.

4. Abide by the standards and protocols developed by the state committee.

5. On a case-by-case basis, request that the state committee review the data of a particular case.

(4) ANNUAL STATISTICAL REPORT.—The state committee shall prepare and submit a comprehensive statistical report by December 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes data, trends, analysis, findings, and recommendations for state and local action regarding deaths from child abuse. Data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include:

(a) Descriptive statistics, including demographic information regarding victims and caregivers, and the causes and nature of deaths.

(b) A detailed statistical analysis of the incidence and causes of deaths.

(c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those issues from both the state and local committees.

(d) Other recommendations to prevent deaths from child abuse based on an analysis of the data presented in the report.

(5) ACCESS TO AND USE OF RECORDS.—

(a) Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:

1. Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under chapter 393, chapter 394, or chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and $1 per fiche for microfiche records.

2. Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Families, the Department of Health, the Department of Education, or the Department of Juvenile Justice.

(b) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.

(c) The state committee and any local committee may share with each other any relevant information that pertains to the review of the death of a child.

(d) A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.

(e) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in

any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.

(f) This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.

(g) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this ¹paragraph does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This ¹paragraph does not apply to any person who admits to committing a crime.

(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—

(a) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.

(b) To the extent that funds are available, the Department of Health may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.

(c) For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the State Surgeon General may substitute an existing entity whose function and organization includes the function and organization of the committees established by this section.

(7) DEPARTMENT OF CHILDREN AND FAMILIES RESPONSIBILITIES.—Each regional managing director of the Department of Children and Families must appoint a child abuse death review coordinator for the region. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:

(a) Coordinating with the local child abuse death review committee.

(b) Ensuring the appropriate implementation of the child abuse death review process and all regional activities related to the review of child abuse deaths.

(c) Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.

(d) Maintaining a system of logging child abuse deaths covered by this procedure and tracking cases during the child abuse death review process.

(e) Conducting or arranging for a Florida Safe Families Network record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.

(f) Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.

(g) Notifying the regional managing director, the Secretary of Children and Families, the Department of Health Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all deaths meeting criteria for review as specified in this section within 1 working day after case closure.

(h) Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the regional managing director and the Secretary of Children and Families.

(i) Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.

History.—s. 13, ch. 99-168; s. 11, ch. 2000-160; s. 8, ch. 2000-217; s. 13, ch. 2001-53; s. 14, ch. 2004-350; s. 41, ch. 2008-6; s. 69, ch. 2014-19; s. 21, ch. 2014-224; s. 4, ch. 2015-79.

[1]Note.—The word "paragraph" was substituted for the word "subsection" by the editors to conform to the redesignation of subsection (14) as paragraph (5)(g) by s. 4, ch. 2015-79.

APPENDIX B:

State and Local Committee Membership

Florida Child Abuse Death Review State Committee Membership

Social Worker
Robin Perry, Ph.D., Chairperson

Department of Health
Patricia Boswell, MPH

Department of Legal Affairs
Stephanie Bergen, JD

Department of Children and Families
Lesline Anglande-Dorleans, JD

Department of Law Enforcement
Seth Montgomery

Department of Education
Iris Williams, MSW

Florida Prosecuting Attorneys Association
Thomas Bakkedahl, JD

Florida Medical Examiners Commission
Anthony Jose Clark, M.D.

Child Protection Team Statewide Medical Director
Bruce McIntosh, M.D.

Public Health Nurse
Deborah Hogan, RN, MPH

Mental Health Professional
April Lott, LCSW

Department of Children and Families Supervisor
Pattie Medlock

Medical Director, Child Protection Team
Mark Kesler, M.D.

Child Advocacy Organization
Jennifer Ohlsen, MS

Paraprofessional in patient resources, child abuse prevention program
Marie Alaniz

Law Enforcement Officer
Deputy Jason Comans

Florida Coalition Against Domestic Violence
Brandy Carlson, MSW

Child Abuse Prevention Program
Zackary Gibson

Substance Abuse Professional
Linda Mann, LCSW, CAP

Florida Child Abuse Death Review
Local Committee Chairpersons

Committee 1 & 2
Kirsten Bucey

Committee 3
Monique Gorman

Committee 4
Evelyn Goslin, Ph.D.

Committee 5
Stephanie Cox

Committee 6, 7, 8
Vicki Whitfield

Committee 9
Denis Conus

Committee 10
Jeanie Raciti

Committee 11
Michelle Akins

Committee 12
Sharon Greene, MBA, CHES

Committee 13
Barbara Lesh

Committee 14
Lauren Lazarus Sabatino, Esq.

Committee 15
Jackie Stephens, MA

Committee 16
Francie Donnorummo

Committee 17
Laura McIntyre, M.A.

Committee 18
Dr. Stephen Nelson

Committee 19
Major Connie Shingledecker

Committee 20
Vacant - Chairperson

Committee 21
Karen Yatchum

Committee 22
Jon Wisenbaker

Committee 23
Laly Serraty

Committee 24
Edie Neal

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APPENDIX C:

Guidelines for the State Committee

Guidelines for the State Committee

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CHAPTER I

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

The Florida Child Abuse Death Review Committee was established by statute in s. 383.402, F.S., in 1999. The committee is established within the Department of Health, and utilizes state and local multi-disciplinary committees to review the facts and circumstances of all child deaths reported as suspected abuse or neglect and accepted by the Florida Abuse Hotline Information System within the Department of Children and Families (DCF). The major purpose of the committees is to make and implement data-driven recommendations for changes to law, rules and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable deaths.

1.2 Mission Statement

Through systemic review and analysis of child deaths, identify and implement prevention strategies to eliminate child abuse and neglect deaths.

1.3 Operating Principle

A public health approach to child maltreatment is needed to address the range of conditions that place children at risk of harm. The circumstances involved in most child abuse and neglect deaths are multidimensional and require a data driven systemic review to identify successful prevention and intervention strategies.

The state and local review committees shall work cooperatively.

- The primary function of the state review committee is to provide direction and leadership for the review system and to analyze data and recommendations from local review committees
- To identify issues and trends and to recommend statewide action

1.4 Goal

The goal of Child Abuse Death Review Committee is to improve our understanding of the causes and contributing factors of deaths resulting from child abuse and neglect, to influence policies and programs to improve child health, safety and protection; and to eliminate preventable child deaths.

1.5 Objectives

- Develop a system and protocol for uniform collection of child abuse and neglect death data statewide, utilizing existing data-collection systems to the greatest extent possible
- Identify needed changes in legislation, policy and practices, and expand efforts in child health and safety to prevent child abuse and neglect deaths

- Improve communication and linkages among agencies and enhance coordination of efforts

CHAPTER 2

STATE REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Introduction

This chapter describes the general standards for the State Child Abuse Death Review Committee membership, and outlines general duties and responsibilities of committee members.

2.2 Statutory Membership

The State Child Abuse Death Review Committee is composed of representatives of the following departments, agencies or organizations:

- Department of Health - The Department of Health representative serves as the state committee coordinator.
- Department of Legal Affairs
- Department of Children and Families
- Department of Law Enforcement
- Department of Education
- Florida Prosecuting Attorneys Association
- Florida Medical Examiners Commission, whose representative must be a Forensic Pathologist

In addition, the State Surgeon General is responsible for appointing the following members based on recommendations from the Department of Health and affiliated agencies, and ensuring that the Committee represents to the greatest possible extent, the regional, gender, and ethnic diversity of the state:

- The Department of Health Statewide Medical Director for Child Protection Team
- A public health nurse
- A mental health professional who treats children or adolescents
- An employee of the Department of Children and Families who supervises family services counselors and who has at least five years of experience in child protective investigations
- A medical director of a Child Protection Team
- A member of a child advocacy organization
- A social worker who has experience in working with victims and perpetrators of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A law enforcement officer who has at least five years of experience in children's issues
- A representative of the Florida Coalition Against Domestic Violence
- A representative from a private provider of programs on preventing child abuse and neglect
- A Substance Abuse Treatment Professional

2.3 Term of Membership

The members of the state committee shall be appointed to staggered terms not to exceed 2 years each as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.
Agency representatives who leave their agency during their term must notify the agency head, and the DOH Child Abuse Death Review Committee Coordinator. The agency appointment expires upon the effective date of the member's departure from the agency and the State Surgeon General will request that the agency appoint a new member.

State Surgeon General appointees who resign from their current position must notify the DOH Child Abuse Death Review Committee Coordinator. At the discretion of the Surgeon General, they may remain on the state Committee provided they are still active in their appointed discipline and continue to be employed in the specific job category where indicated. All appointees who leave their employment and otherwise cease to be active in their designated discipline must notify the Chair of the State Committee and the DOH Death Review Committee Coordinator.

All replacements to the state Committee will serve the remainder of the term for the appointee they replace.

2.4 Consultants

The Department of Health may hire staff or consultants to assist the review committee in performing its duties. Consultants must be able to provide important information, experience, and expertise to the Committee. They may not use their participation on the Committee to discover, identify, acquire or use information for any purpose other than the stated purpose of conducting approved child abuse death review activities.

2.5 Election of State Chairperson

The chairperson of the State Child Abuse Death Review Committee is elected for a two (2) year term by a majority vote of the members of the State Child Abuse Death Review Committee. Members of the committee with investigatory responsibilities are not eligible to serve as chairperson. The State Child Abuse Death Review Committee Chairperson may appoint ad hoc committees as necessary to carry out the duties of the Committee.

2.6 Reimbursement

Members of the state Committee serve without compensation but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061, F.S., and to the extent that funds are available. Consultants can be reimbursed reasonable expenses to the extent that funds are available. Requests for funding must be reviewed and approved by the Child Death Review Committee Coordinator.

2.7 Terminating State Committee Membership

A member or a consultant of the State Child Abuse Death Review Committee may resign at any time**.** A written resignation shall be submitted to the Child Death Review Committee Coordinator. Should action be required, a letter shall be addressed to the State Surgeon General who will either make a new appointment or contact the agency head requesting the designation of a new representative.

2.8 State Review Committee Duties

Chairperson

- Chair Committee meetings
- Ensure that the Committee operates according to guidelines and protocols
- Ensure that all new Committee members and ad hoc members sign a confidentiality agreement

Department of Health Committee Coordinator/Department of Health, Death Review Coordinator for the State CADR or designee

- Send meeting notices to committee members
- Submit child abuse death review data to the State Committee for review and analysis
- Maintain current roster and bibliography of members, attendance records and minutes

All Committee Members

- Develop a system for collecting data from local committees on deaths that are reported to the central abuse hotline. The system must include a protocol for the uniform collection of data statewide, which must, at a minimum, use the National Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths, deaths that are reported to the central abuse hotline
- Provide training to cooperating agencies, individuals and local child abuse death review committees on the use of the child abuse death data system
- ANNUAL STATISTICAL REPORT— prepare and submit a comprehensive statistical report by December 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes data, trends, analysis, findings, and recommendations for state and local action regarding deaths from child abuse. Data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include:
  - (a) Descriptive statistics, including demographic information regarding victims and caregivers, and the causes and nature of deaths.
  - (b) A detailed statistical analysis of the incidence and causes of deaths.
  - (c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those issues from both the state and local committees.
  - (d) Other recommendations to prevent deaths from child abuse based on an analysis of the data presented in the report.

- Encourage and assist in developing the local child abuse death review committees and provide consultation on individual cases to local committees upon request

- Develop guidelines, standards and protocols, including a protocol for data collection for local child abuse death review committees and provide training technical assistance to local committees upon request

- Provide training on the dynamics and impact of domestic violence, substance abuse or mental health disorders when there is a co-occurrence of child abuse. Training shall be provided by the Florida Coalition Against Domestic Violence, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise

- Develop guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities and social service agencies

- Study the adequacy of laws, rules, training and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes

- Educate the public regarding the incidence and causes of child abuse death, and the ways to prevent such deaths

- Provide continuing education for professionals who investigate, treat and prevent child abuse or neglect

- Recommend, when appropriate, the review of the death certificate of a child who is suspected to have died of abuse or neglect

CHAPTER 3

MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

The work of the Committee requires regular attendance and participation by all Committee members. Regularly scheduled meetings allow Committee members to make long-term plans and allow for better attendance. Members should become acquainted with protocol for data collection and analysis and come prepared to present their agencies' information and perspectives.

Each member agrees to keep meeting discussions and information regarding specific child abuse and neglect deaths confidential. Confidentiality is essential for each agency to fully participate in the meetings. Committee members are reminded of the following by the Chairperson.

- The review Committee is not an investigative body

- All participants agree to keep Committee discussions relating to specific child abuse deaths confidential

- Meeting minutes will not indicate any case specific information

- The purpose of the Committee is to improve services and agency practices by identifying issues and trends related to child abuse deaths and provide recommendations to address these issues and prevent other child deaths

Each professional brings to the review Committee a unique perspective, professional knowledge and expertise. Each member must acknowledge and respect the professional role of each participating agency.

This reference provides guidelines for the development, implementation, and management of the State Child Abuse Death Review Committee and will be reviewed bi-annually or more often if necessary. Revisions will be distributed to all committee members and posted to the Child Abuse Death Review website.

3.2 Focus on Prevention

The key to good prevention is implementation at the local level. Review Committee members can provide leadership by serving as catalysts for community action. Prevention efforts can range from simply changing one agency practice or policy or setting up more complex interventions for high-risk parents.

The State Committee should work with local committees and community programs involved in child death, safety and protection. Some communities have child safety coalitions, prevention coalitions or active citizen advocacy groups. Connect state and local Committee findings to ensure results. Assist these groups in accessing state and national resources in the prevention areas targeted by their communities.

CHAPTER 4

COMMITTEE OPERATING PROCEDURES

4.1 Obtaining Data from Local Committee Reviews

The Chairperson should work closely with the local committees and the state CADR Committee designee to ensure receipt of data from local committees.

Additionally, any meeting notes that directly relate to a specific child must also be secured and separate from general meeting notes.

4.2 Record Keeping and Retention

All records (e.g., completed data forms with attachments, copies of agency department files) must be maintained in a secure area.

All correspondence, public records requests, letters, and communications with the State Chairperson or other Committee members must be copied to Florida Department of Health Child Abuse Death Review Coordinator.

- Pursuant to State of Florida Department of State Record Retention Schedule #34 the State Child Abuse Death Review Committee shall retain a permanent copy of each annual report, either electronically or written.

- State of Florida Department of State Record Retention Schedule #35 addresses copies of documents received from third parties (e.g. individuals, entities, and government agencies) by the State and Local Child Abuse Death Review Committees pursuant to the review of child abuse deaths and for the preparation of the annual incidence and causes of death report required by Section 383.402, F.S. Record copies must be maintained for a period of one year from the date of publication of the annual report. Permission must be obtained from the Florida Department of Health State Child Abuse Death Review Coordinator prior to the destruction of any record

- Documents produced by the State or Local Child Abuse Death Review Committee (e.g., the data form, death summary report, or listing of records reviewed, etc.) must be maintained pursuant to State of Florida Department of State Record Retention Schedule GS1-S, item #338 for a period of five years. Permission must be obtained from the Florida Department of Health State Child Abuse Death Review Coordinator prior to the destruction of any record.

- Committee members must adhere to s. 286.011, F.S. (Florida's Government in the Sunshine Law), and can only communicate with one another about any committee business during a properly noticed meeting

4.3 Child Abuse Death Review Case Reporting System

The State Child Abuse Death Review Committee utilizes the national Child Death Review Case Reporting System to record and track data from child death reviews. The System Guide provides instructions for completing the data form. The Child Death Review Case Reporting System Case Report must be completed on all child abuse deaths reviewed. The committee coordinator should review the data form to ensure that all information is accurate and that the case review is complete.

CHAPTER 5

CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

As provided in section 383.412, Florida Statutes., all information and records that are confidential or exempt under Florida's public records laws shall retain that status throughout the child abuse death review process, including, but not limited to the following:

- Information that reveals the identity of the siblings, surviving family members, or others living in home of a deceased child
- Any information held by the State Child Abuse Death Review Committee or a local committee which reveals the identity of a deceased child whose death has been reported to the central abuse hotline but determined not to be the result of abuse or neglect, or the identity of the surviving siblings, family members, or others living in the home of such deceased child.
- Portions of meetings of the state or local child death review committees at which confidential, exempt information is discussed
- Recordings of closed meetings

Pursuant to Section 383.412, Florida Statutes, , a person who violates the confidentiality provisions of this statute is guilty of a first degree misdemeanor. Violation of confidentiality provisions by committee members should be referred to the representative agency/organization for appropriate action,

Specific questions regarding confidentiality of child abuse death review information should be directed to the Department of Health, Child Abuse Death Review Committee Coordinator. The Coordinator will seek advice on the issue, as needed, from the Department of Health Office of General Counsel

The State Child Abuse Death Review Committee and local committees may share information made confidential and exempt by this section:
(a) With each other;
(b) With a governmental agency in furtherance of its duties; or
(c) With any person or entity authorized by the Department of Health to use such relevant information for bona fide research or statistical purposes. A person or entity who is authorized to obtain such relevant information for research or statistical purposes must enter into a privacy and security
agreement with the Department of Health and comply with all laws and rules governing the use of such records and information for research or statistical purposes. Anything identifying the

subjects of such relevant information must be treated as confidential by the person or entity and may
not be released in any form

5.2 Confidentiality Statements

Any person who may have access to any information or records regarding review of a child abuse death is required to sign a statement of confidentiality. Persons who may have access to this information shall include state and local Committee chairpersons, state and local Committee members, administrative and support staff for the state and local Committees who open or handle mail, birth or death certificates, records, or any other components required in the preparation of a child abuse death review case.

Each child abuse and neglect death review Committee shall maintain a file with signed copies of the member's confidentiality statement. Other confidentiality statements must be obtained for non-Committee member participants, as needed, on a case-by-case basis. These should be maintained in the local Committee's file.

5.3 Protecting Family Privacy

A member or consultant of the State Child Abuse Death Review Committee shall not contact, interview, or obtain information by request or subpoena from a member of the deceased child's family. This does not apply to a member or consultant who makes such contact as part of his or her other official duties. Such member or consultant shall make no reference to his/her role or duties with the Child Abuse Death Review Committee.

5.4 Document Storage and Security

All information, records and documents for child abuse death review cases shall be stored in locked files. Persons who have access to the locked files or information contained therein shall be required to sign a confidentiality statement.

Copies of documents provided for Committee meetings shall not be taken from Committee meetings. At the conclusion of the Committee meeting, the copies shall be collected and destroyed.

Data about the circumstances surrounding the death of a child is entered into the Child Abuse Death Review Data System from the Child Abuse Death Review Data Form. This secure database is used to generate summary or management reports and statistical summaries or analyses.

5.5 Media Relations and Public Records Request

Public record requests or other media inquiries should be referred to the Florida Department of Health Child Abuse Death Review Committee Coordinator

CHAPTER 6

CHILD ABUSE DEATH REVIEW ANNUAL REPORT

6.1 Guidelines for Report

The State Child Abuse Death Review Committee is required to provide an annual report to the Governor, President of the Senate and Speaker of the House of Representatives by December 1st. The report will summarize information gathered by the local committees resulting from their review of specific cases meeting statutory review criteria. The report will contain the following sections.

A) Background

- Program Description
- Statutory Authority
- Program Purpose
- Membership of the State Committee
- Local Child Abuse Death Review Committees

B) Method

- Overview of Child Death Data
- Department of Health Data on all Children Ages 0 through 17 years

C) Findings-Trend Analysis Based on Three Years of Data

- Causes of Death (Abuse & Neglect)
- Age at Death
- Gender and Race
- Age and Relationship of Caregiver(s) Responsible
- Child and Family Risk Factors

D) Conclusions

E) Prevention Recommendations

F) Summary

APPENDIX D:

Guidelines for Local Committees

Guidelines for Local Committees

July 2015

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CHAPTER I

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

The Florida Child Abuse Death Review Committee (CADR) was established in 1999, in Section 383.402, *Florida Statutes* (appendix A). The committee is established within the Department of Health (DOH), and utilizes state and local multi-disciplinary committees to review the facts and circumstances of all child deaths reported as suspected abuse or neglect and accepted by the Florida Abuse Hotline Information System (FAHIS) within the Department of Children and Families (DCF). The major purpose of the committees is to recommend changes in law, rules and policies at the state and local levels, as well as develop practice standards that support the safe and healthy development of children and reduce preventable deaths.

1.2 Mission Statement

Through systematic review and analysis of child deaths, identify and implement prevention strategies to eliminate child abuse and neglect deaths.

1.3 Operating Principle

A public health approach to child maltreatment is needed to address the range of conditions that place children at risk of harm. The circumstances involved in most child abuse and neglect deaths are multidimensional and require a data driven systematic review to identify successful prevention and intervention strategies.

The state and local review committees shall work cooperatively. The primary function of the local review committees is to conduct individual case reviews of deaths, generate information, make recommendations, and implement improvements at the local level.

1.4 Goal

The goal of Child Abuse Death Review Committee is to improve our understanding of the causes and contributing factors of deaths resulting from child abuse and neglect, to influence policies and programs to improve child health, safety and protection, and to eliminate preventable child deaths.

1.5 Objectives

- Develop a system and protocol for uniform collection of child abuse and neglect death data statewide, utilizing existing data-collection systems to the greatest extent possible
- Identify needed changes in legislation, policy and practices, and expand efforts in child health and safety to prevent child abuse and neglect deaths
- Improve communication and linkages among agencies and enhance coordination of efforts

CHAPTER 2

LOCAL REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Committee Membership

Local committees enable various disciplines to come together on a regular basis and combine their expertise to gain a better understanding of the causes and contributing factors of child abuse deaths in their jurisdictions.

The directors of county health departments or designee will convene and support a. county or multi-county review committees. The local death review committees shall include, at a minimum, the following organizations' representatives, appointed by the county health department directors in consultation with those organizations:

- State Attorney's Office
- County Health Department
- District Medical Examiner's Office
- Local Child Protective Investigations
- Local Child Protection Team
- The Community-based Care lead agency
- State, County, or Local Law Enforcement
- Local School District
- A mental health treatment provider
- A certified domestic violence center
- A substance abuse treatment provider

Other Committee members may include representatives of specific agencies from the community that provide services to children and families. Local child abuse death review core members should identify appropriate representatives from these agencies to participate on the committee. Suggested members include the following:

- A board-certified pediatrician or family practice physician
- A public health nurse
- A member of a child advocacy organization
- A social worker who has experience in working with victims and perpetrators of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A representative from a private provider of programs on preventing child abuse and neglect

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child shall attend any meetings where the child's case is reviewed. This participation can be of value in assisting the local committees in their critical appraisal of information that can aid in the evaluation of circumstances surrounding a death (not re-investigation of a case), identification of local trends and

specific issues contributing to child abuse and neglect fatalities within their region, and the development of prevention recommendations in keeping with the mission of the Statewide Child Abuse Death Review Committee.

2.2 Term of Membership

Members of the Local Child Abuse Death Review Committee are appointed for two year terms and may be reappointed. Agency representatives who leave their agency during their term must notify the Chairperson of the local committee, who will notify the County Health Department representative. All replacements to the local committee are appointed for a new two year term.

2.3 Consultants

To the extent that funds are available, the Department of Health may hire staff or consultants to assist the review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the local committee. Consultants must be able to provide important information, experience, and expertise to the Committee. They may not use their participation on the Committee to discover, identify, acquire or use information for any purpose other than the stated purpose of conducting approved child abuse death review activities.

2.4 Ad Hoc Members

Committees may designate ad hoc members. They attend meetings only when they have been directly involved in a case scheduled for review or to provide information on committee related activities. They may be DCF child protective investigators or family services counselors involved in a specific case, law enforcement officers from a police agency that handled the case or a service provider or child advocate who worked with a family.

2.5 Local Review Committee Duties

The duties of the Local Child Abuse Death Review Committee are:

- Assist the state committee in collecting data on deaths that are reported to the child abuse hotline within the Department of Children and Families
- Collect data on applicable child deaths for the State Child Abuse Death Review Committee utilizing the National Child Death Review Case Reporting System
- Maintain a record of attendance, minutes and audio recording of the committee meetings
- Submit written reports to the state committee as directed and in keeping with the intent of the law as denoted in Appendix A. The reports must include:
- a. Nonidentifying information from individual cases.
- b. Identification of any problems with the data system uncovered through the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.
- c. All steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

2.6 Local Committee Member Responsibilities

The role of local committee members can be flexible to meet the needs of particular communities. Each member should:

- Contribute information from his or her records, in accordance with Section 383.402, *Florida Statutes* (see Appendix A)
- Serve as a liaison to respective professional counterparts
- Provide definitions or professional terminology
- Interpret agency procedures and policies
- Explain the legal responsibilities or limitations of his or her profession

All committee members must have a clear understanding of their own and other professional and agency roles and responsibilities in their community's response to child abuse and neglect fatalities.

2.7 Orientation and Training of Local Committee Members

Orientation and ongoing training of review committees is required to maintain consistency in application of review methods, data review and collection activities. One of the primary goals of this training is to develop consistent, accurate, and thorough application of program standards, and to help ensure that meaningful information can be obtained for identification of prevention strategies for reduction of child abuse and neglect deaths.

Local committees will work in collaboration with the Department of Children and Families Child Fatality Prevention Specialist and the State Child Abuse Death Review Committee for planning and conducting these training activities, especially during the first several meetings of the local committee.

Orientation should include, at a minimum, review of the Child Abuse Death Review Guidelines with an emphasis on confidentiality of records and information, Section 286.011, *Florida Statutes (*Florida Sunshine Law; see Appendix B) and any other training required by Section 383.402, *Florida Statutes,* including:

- Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.
- Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse.
- Develop guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.
- Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.

2.8 Support and Technical Assistance for Local Committees

The State Child Abuse Death Review Committee recognizes the importance of consistency and accuracy in the information provided by local child abuse death review Committees. Without this consistency, information collected about the reasons for child abuse and neglect deaths may not be reliable or accurate. To this end, the State Child Abuse Death Review Committee will provide training and technical assistance for local Committee members.

Local Committees may request technical assistance directly from the State Child Abuse Death Review Committee; requests should be directed to the State Committee Chairperson or the DOH State Child Abuse Death Review Coordinator.

CHAPTER 3

MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

The work of the Committee requires regular attendance and participation by all committee members. Regularly scheduled meetings allow committee members to make long-term plans and allow for better attendance. Members should become acquainted with protocol for data collection and analysis and come prepared to present their agencies' information and perspectives.

Each member agrees to keep meeting discussions and information regarding specific child abuse and neglect deaths confidential. Confidentiality is essential for each agency to fully participate in the meetings. Committee members are reminded of the following by the Chairperson:

- The review Committee is not an investigative body
- All participants agree to keep Committee discussions relating to specific child abuse deaths confidential
- Meeting minutes will not indicate any case specific information
- The purpose of the Committee is to improve services and agency practices by identifying issues and trends related to child abuse deaths and provide recommendations to address these issues and prevent other child deaths

Each professional brings to the review Committee a unique perspective, professional knowledge and expertise. Each member must acknowledge and respect the professional role of each participating agency.

Committee members must adhere to Section 286.011, *Florida Statutes* (Florida's Government in the Sunshine Law; see Appendix B), and can only communicate with one another about any committee business during a properly noticed meeting.

3.2 Beginning the Meeting

Members and ad hoc members sign the Child Abuse Death Review Signature Sheet outlining confidentiality policies prior to the start of their participation in review meetings. A confidentiality agreement (see Appendix D) signed by committee members and required for other meeting attendees should be kept at each meeting by the Committee Coordinator.

3.3 Sharing Information

Reviews are conducted by discussing each child abuse death individually. It can be helpful to establish the order in which information will be presented. This will help the meetings and reviews to run more smoothly and make completing the data form easier. Each participant provides information from their agency's records. If any information is distributed, it must be collected before the end of the meeting.

Often committee members may be unable to share information due to confidentiality restrictions or lack of information. If there is insufficient information available at the time of the review, the Committee may postpone the review of that case until additional information is available.

3.4 Community Education and Prevention

The state and local Child Abuse Death Review Committees review and analyze information on the nature of child abuse deaths in Florida. The key to good prevention is leadership at the local level. Local committees identify trends in child abuse death statistics for their own communities, and develop and implement community education and prevention plans that are data-driven. Prevention efforts can range from simply changing one agency practice or policy or setting up more complex interventions for high-risk parents.

Review committees should work with local community programs involved in child death, safety and protection. Some communities have child safety coalitions, prevention coalitions or active citizen advocacy groups. Connect review findings to these groups to ensure results. Also, assist these groups in accessing state and national resources in the prevention areas targeted by the community.

CHAPTER 4

COMMITTEE OPERATING PROCEDURES

4.1 Information Sharing

Background and current information from Committee members' records and other sources is necessary for case reviews. Committees can request information and records as needed to carry out their duties in accordance with state statutes. Such requests should be addressed to the "custodians of the records" or agency director and should include the review Committee authorizing statute, information regarding the Committee's operation and purpose, and a copy of the Committee's interagency agreement.

4.2 Committee Chairperson

A Committee chairperson should be selected biennially at the organizational meeting. The chairperson, who can be one of the committee members, serves at the discretion of the committee.

Chairperson duties:

- Call and chair committee meetings. Meetings should be held at least quarterly, or as often as needed to review cases and to discuss community prevention initiatives (quarterly meetings will be conducted even when there are no case files for review).
- Send meeting notices to committee members.
- Chairperson is to ensure that meetings are conducted according to Section 286.011, *Florida Statutes* (Florida's Government in the Sunshine Law).
- Work with DOH staff to obtain names and compile the summary sheet of child abuse deaths to be reviewed for distribution to committee members two weeks prior to each meeting.
- Obtain all records needed for the local reviews in accordance Section 383.402, *Florida Statutes.*
- Submit completed child abuse death review data forms with attached materials to the Department of Health, Death Review Coordinator for the State CADR or designee.
- Ensure that the Committee operates according to protocols as adapted by the Committee.
- Ensure that all new Committee members and ad hoc members sign a confidentiality agreement.

- Maintain attendance records, current roster, and resumes or CVs detailing qualifications and experience of members.
- Ensure secure transfer of all records to new Chairperson upon transfer of duties.

4.3 Meeting Attendance

Committee members must recognize the importance of regular attendance as a means of sharing the expertise and knowledge for which they were recruited. Attendance at meetings must be in person to ensure maximum participation in the death review process. For confidentiality reasons, phone conferencing is not acceptable. Local committees should develop a policy to address non-attendance of committee members.

4.4 Obtaining Names for Committee Reviews

The Chairperson should work closely with the DCF Child Fatality Prevention Specialist to ensure notification of deaths that meet criteria for review.

4.5 Record Keeping and Retention

All records (e.g., completed data forms with attachments, copies of agency department files) must be maintained in a secure area within locked files and may not be destroyed without permission from the Department of Health Death Review Coordinator or designee.

All correspondence, public records requests, letters, and communications with the State Chairperson or other Committee members must be copied to Florida Department of Health Child Abuse Death Review Coordinator or designee.

- Pursuant to State of Florida Department of State Record Retention Schedule #34 the State Child Abuse Death Review Committee shall retain a permanent copy of each annual report, either electronically or written.
- State of Florida Department of State Record Retention Schedule #35 addresses copies of documents received from third parties (e.g. individuals, entities, and government agencies) by the State and Local Child Abuse Death Review Committees pursuant to the review of child abuse deaths and for the preparation of the annual incidence and causes of death report required by Section 383.402, *Florida Statutes*. Record copies must be maintained for a period of one year from the date of publication of the annual report. Permission must be obtained from the Florida Department of Health State Child Abuse Death Review Coordinator or designee prior to the destruction of any record.
- Documents produced by the State or Local Child Abuse Death Review Committee (e.g., the data form, death summary report, or listing of records reviewed, etc.) must be maintained pursuant to State of Florida Department of State Record Retention Schedule GS1-S, item #338 for a period of five years. Permission must be obtained from the Florida Department of Health State Child Abuse Death Review Coordinator or designee prior to the destruction of any record.
- Committee members must adhere to Section 286.011, *Florida Statutes* (Florida's Government in the Sunshine Law), and can only communicate with one another about any committee business during a properly noticed meeting.

4.6 Child Abuse Death Review Case Reporting System

The Child Abuse Death Review Committees utilize the national Child Death Review Case Reporting System to record and track data from child death reviews. The System Guide provides instructions for

completing the data form. The Child Death Review Case Reporting System Case Report must be completed on all child abuse deaths reviewed. The committee chair should review the data form to ensure that all information is accurate and that the case review is complete.

CHAPTER 5

CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

As provided in Section 383.412, *Florida Statutes* (Appendix C) all information and records that are confidential or exempt under Florida's public records laws shall retain that status throughout the child abuse death review process, including, but not limited to the following:

- Any Information that reveals the identity of the surviving siblings of a deceased child whose death occurred as the result of a verified report of abuse or neglect
- Any information that reveals the identity of a deceased child whose death has been reported to the central abuse hotline but determined not to be the result of abuse or neglect, or the identity of the surviving siblings, family members, or others living in the home of such deceased child
- Portions of meetings of the state or local child death review committees at which confidential, exempt information is discussed
- Recordings of closed meetings

Pursuant to Section 383.412, *Florida Statutes*, a person who violates the confidentiality provisions of this statute is guilty of a first degree misdemeanor. Violation of confidentiality provisions by committee members should be referred to the representative agency/organization for appropriate action.

Specific questions regarding confidentiality of child abuse death review information should be directed to the Department of Health, Child Abuse Death Review Committee Coordinator or designee. The Coordinator will seek advice on the issue, as needed, from the Department of Health, Office of the General Counsel.

5.2 Confidentiality Statements

Any person who may have access to any information or records regarding review of a child abuse death is required to sign a statement of confidentiality (Appendix D). Persons who may have access to this information shall include state and local committee chairpersons, state and local committee members, administrative and support staff for the state and local committees who open or handle mail, birth or death certificates, records, or any other components required in the preparation of a child abuse death review case.

Each child abuse and neglect death review Committee shall maintain a file with signed copies of the member's confidentiality statement. Other confidentiality statements must be obtained for non-committee member participants, as needed, on a case-by-case basis. These should be maintained in the local Committee's file.

5.3 Protecting Family Privacy

A member or consultant of the local review committee shall not contact, interview, or obtain information by request or subpoena from a member of the deceased child's family. This does not apply to a member or consultant who makes such contact as part of his or her other official duties. Such member or consultant shall make no reference to his/her role or duties with the Child Abuse Death Review Committee.

5.4 Document Storage and Security

All information, records and documents for child abuse death review cases must be maintained in a secure area within locked files. Persons who have access to the locked files or information contained therein shall be required to sign a confidentiality statement.

Copies of documents provided for Committee meetings shall not be taken from Committee meetings. At the conclusion of the Committee meeting, the copies provided to members for the review purposes shall be collected and destroyed.

Data about the circumstances surrounding the death of a child is entered into the Child Abuse Death Review Data System from the Child Abuse Death Review Data Form. This secure database is used to generate summary or management reports and statistical summaries or analyses.

5.5 Media Relations and Public Records Request

Public record requests or other media inquiries should be referred to the Florida Department of Health Child Abuse Death Review Committee Coordinator or designee.

383.402 Child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committees.—

(1) INTENT.—It is the intent of the Legislature to establish a statewide multidisciplinary, multiagency, epidemiological child abuse death assessment and prevention system that consists of state and local review committees. The committees shall review the facts and circumstances of all deaths of children from birth to age 18 which occur in this state and are reported to the central abuse hotline of the Department of Children and Families. The state and local review committees shall work cooperatively. The primary function of the state review committee is to provide direction and leadership for the review system and to analyze data and recommendations from local review committees to identify issues and trends and to recommend statewide action. The primary function of the local review committees is to conduct individual case reviews of deaths, generate information, make recommendations, and implement improvements at the local level. The purpose of the state and local review system is to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.

(b) Whenever possible, develop a communitywide approach to address such causes and contributing factors.

(c) Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse.

(d) Recommend changes in law, rules, and policies at the state and local levels, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.

(e) Implement such recommendations, to the extent possible.

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) Membership.—

1. The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the State Surgeon General, who shall serve as the state committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

a. The Department of Legal Affairs.

b. The Department of Children and Families.

c. The Department of Law Enforcement.

d. The Department of Education.

e. The Florida Prosecuting Attorneys Association, Inc.

f. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

2. In addition, the State Surgeon General shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies listed in subparagraph 1., and ensuring that the committee represents the regional, gender, and ethnic diversity of the state to the greatest extent possible:

a. The Department of Health Statewide Child Protection Team Medical Director.

b. A public health nurse.

c. A mental health professional who treats children or adolescents.

d. An employee of the Department of Children and Families who supervises family services counselors and who has at least 5 years of experience in child protective investigations.

e. The medical director of a child protection team.

f. A member of a child advocacy organization.

g. A social worker who has experience in working with victims and perpetrators of child abuse.

h. A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program.

i. A law enforcement officer who has at least 5 years of experience in children’s issues.

j. A representative of the Florida Coalition Against Domestic Violence.
k. A representative from a private provider of programs on preventing child abuse and neglect.
l. A substance abuse treatment professional.
3. The members of the state committee shall be appointed to staggered terms not to exceed 2 years each, as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.
4. Members of the state committee shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.
(b) Duties.—The State Child Abuse Death Review Committee shall:
1. Develop a system for collecting data from local committees on deaths that are reported to the central abuse hotline. The system must include a protocol for the uniform collection of data statewide, which must, at a minimum, use the National Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths.
2. Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.
3. Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse. Training must be provided by the Florida Coalition Against Domestic Violence, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise.
4. Develop statewide uniform guidelines, standards, and protocols, including a protocol for standardized data collection and reporting, for local child abuse death review committees and provide training and technical assistance to local committees.
5. Develop statewide uniform guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.
6. Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.
7. Provide consultation on individual cases to local committees upon request.
8. Educate the public regarding the provisions of Chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.
9. Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.
10. Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.
(3) LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES.—At the direction of the State Surgeon General, a county or multicounty child abuse death review committee shall be convened and supported by the county health department directors in accordance with the protocols established by the State Child Abuse Death Review Committee.
(a) Membership.—The local death review committees shall include, at a minimum, the following organizations' representatives, appointed by the county health department directors in consultation with those organizations:
1. The state attorney's office.
2. The medical examiner's office.
3. The local Department of Children and Families child protective investigations unit.
4. The Department of Health child protection team.
5. The community-based care lead agency.

6. State, county, or local law enforcement agencies.
7. The school district.
8. A mental health treatment provider.
9. A certified domestic violence center.
10. A substance abuse treatment provider.
11. Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child, shall attend any meetings where the child's case is reviewed. The members of a local committee shall be appointed to 2-year terms and may be reappointed. Members shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) Duties.—Each local child abuse death review committee shall:
1. Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee. The local committee shall complete, to the fullest extent possible, the individual case report in the National Child Death Review Case Reporting System.
2. Submit written reports as required by the state committee. The reports must include:
a. Nonidentifying information from individual cases.
b. Identification of any problems with the data system uncovered through the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.
c. All steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.
3. Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.
4. Abide by the standards and protocols developed by the state committee.
5. On a case-by-case basis, request that the state committee review the data of a particular case.
(4) ANNUAL STATISTICAL REPORT.—The state committee shall prepare and submit a comprehensive statistical report by December 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes data, trends, analysis, findings, and recommendations for state and local action regarding deaths from child abuse. Data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include:
(a) Descriptive statistics, including demographic information regarding victims and caregivers, and the causes and nature of deaths.
(b) A detailed statistical analysis of the incidence and causes of deaths.
(c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those issues from both the state and local committees.
(d) Other recommendations to prevent deaths from child abuse based on an analysis of the data presented in the report.
(5) ACCESS TO AND USE OF RECORDS.—
(a) Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:

1. Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under Chapter 393, Chapter 394, or Chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and $1 per fiche for microfiche records.
2. Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Families, the Department of Health, the Department of Education, or the Department of Juvenile Justice.
(b) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.
(c) The state committee and any local committee may share with each other any relevant information that pertains to the review of the death of a child.
(d) A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.
(e) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.
(f) This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.
(g) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this [1]paragraph does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This [1]paragraph does not apply to any person who admits to committing a crime.
(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—
(a) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.
(b) To the extent that funds are available, the Department of Health may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.
(c) For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the State Surgeon General may substitute an existing entity whose function and organization includes the function and organization of the committees established by this section.
(7) DEPARTMENT OF CHILDREN AND FAMILIES RESPONSIBILITIES.—Each regional managing director of the Department of Children and Families must appoint a child abuse death review coordinator for the region. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:

(a) Coordinating with the local child abuse death review committee.
(b) Ensuring the appropriate implementation of the child abuse death review process and all regional activities related to the review of child abuse deaths.
(c) Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.
(d) Maintaining a system of logging child abuse deaths covered by this procedure and tracking cases during the child abuse death review process.
(e) Conducting or arranging for a Florida Safe Families Network record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.
(f) Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.
(g) Notifying the regional managing director, the Secretary of Children and Families, the Department of Health Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all deaths meeting criteria for review as specified in this section within 1 working day after case closure.
(h) Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the regional managing director and the Secretary of Children and Families.
(i) Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.
History.—s. 13, ch. 99-168; s. 11, ch. 2000-160; s. 8, ch. 2000-217; s. 13, ch. 2001-53; s. 14, ch. 2004-350; s. 41, ch. 2008-6; s. 69, ch. 2014-19; s. 21, ch. 2014-224; s. 4, ch. 2015-79.
[1]Note.—The word "paragraph" was substituted for the word "subsection" by the editors to conform to the redesignation of subsection (14) as paragraph (5)(g) by s. 4, ch. 2015-79.

Appendix B

286.011 Public meetings and records; public inspection; criminal and civil penalties —

(1) All meetings of any board or commission of any state agency or authority or of any agency or authority of any county, municipal corporation, or political subdivision, except as otherwise provided in the Constitution, including meetings with or attended by any person elected to such board or commission, but who has not yet taken office, at which official acts are to be taken are declared to be public meetings open to the public at all times, and no resolution, rule, or formal action shall be considered binding except as taken or made at such meeting. The board or commission must provide reasonable notice of all such meetings.

(2) The minutes of a meeting of any such board or commission of any such state agency or authority shall be promptly recorded, and such records shall be open to public inspection. The circuit courts of this state shall have jurisdiction to issue injunctions to enforce the purposes of this section upon application by any citizen of this state.

(3)(a) Any public officer who violates any provision of this section is guilty of a noncriminal infraction, punishable by fine not exceeding $500.

(b) Any person who is a member of a board or commission or of any state agency or authority of any county, municipal corporation, or political subdivision who knowingly violates the provisions of this section by attending a meeting not held in accordance with the provisions hereof is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(c) Conduct which occurs outside the state which would constitute a knowing violation of this section is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(4) Whenever an action has been filed against any board or commission of any state agency or authority or any agency or authority of any county, municipal corporation, or political subdivision to enforce the provisions of this section or to invalidate the actions of any such board, commission, agency, or authority, which action was taken in violation of this section, and the court determines that the defendant or defendants to such action acted in violation of this section, the court shall assess a reasonable attorney's fee against such agency, and may assess a reasonable attorney's fee against the individual filing such an action if the court finds it was filed in bad faith or was frivolous. Any fees so assessed may be assessed against the individual member or members of such board or commission; provided, that in any case where the board or commission seeks the advice of its attorney and such advice is followed, no such fees shall be assessed against the individual member or members of the board or commission. However, this subsection shall not apply to a state attorney or his or her duly authorized assistants or any officer charged with enforcing the provisions of this section.

(5) Whenever any board or commission of any state agency or authority or any agency or authority of any county, municipal corporation, or political subdivision appeals any court order which has found said board, commission, agency, or authority to have violated this section, and such order is affirmed, the court shall assess a reasonable attorney's fee for the appeal against such board, commission, agency, or authority. Any fees so assessed may be assessed against the individual member or members of such board or commission; provided, that in any case where the board or commission seeks the advice of its attorney and such advice is followed, no such fees shall be assessed against the individual member or members of the board or commission.

(6) All persons subject to subsection (1) are prohibited from holding meetings at any facility or location which discriminates on the basis of sex, age, race, creed, color, origin, or economic status or which operates in such a manner as to unreasonably restrict public access to such a facility.

(7) Whenever any member of any board or commission of any state agency or authority or any agency or authority of any county, municipal corporation, or political subdivision is charged with a violation of this section and is subsequently acquitted, the board or commission is authorized to reimburse said member for any portion of his or her reasonable attorney's fees.

(8) Notwithstanding the provisions of subsection (1), any board or commission of any state agency or authority or any agency or authority of any county, municipal corporation, or political subdivision, and the chief administrative or executive officer of the governmental entity, may meet in private with the entity's attorney to discuss pending litigation to which the entity is presently a party before a court or administrative agency, provided that the following conditions are met:

(a) The entity's attorney shall advise the entity at a public meeting that he or she desires advice concerning the litigation.

(b) The subject matter of the meeting shall be confined to settlement negotiations or strategy sessions related to litigation expenditures.

(c) The entire session shall be recorded by a certified court reporter. The reporter shall record the times of commencement and termination of the session, all discussion and proceedings, the names of all persons present at any time, and the names of all persons speaking. No portion of the session shall be off the record. The court reporter's notes shall be fully transcribed and filed with the entity's clerk within a reasonable time after the meeting.

(d) The entity shall give reasonable public notice of the time and date of the attorney-client session and the names of persons who will be attending the session. The session shall commence at an open meeting at which the persons chairing the meeting shall announce the commencement and estimated length of the attorney-client session and the names of the persons attending. At the conclusion of the attorney-client session, the meeting shall be reopened, and the person chairing the meeting shall announce the termination of the session.

(e) The transcript shall be made part of the public record upon conclusion of the litigation.

History.—s. 1, ch. 67-356; s. 159, ch. 71-136; s. 1, ch. 78-365; s. 6, ch. 85-301; s. 33, ch. 91-224; s. 1, ch. 93-232; s. 210, ch. 95-148; s. 1, ch. 95-353; s. 2, ch. 2012-25.

Appendix C - See Ch. 2015-77, Laws of Fla. @ www.leg.state.fl.us

383.412 Public records and public meetings exemptions.—

(1) For purposes of this section, the term “local committee” means a local child abuse death review committee or a panel or committee assembled by the State Child Abuse Death Review Committee or a local child abuse death review committee pursuant to s. 383.402.

(2)(a) Any information held by the State Child Abuse Death Review Committee or a local committee which reveals the identity of the surviving siblings of a deceased child whose death occurred as the result of a verified report of abuse or neglect is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(b) Any information held by the State Child Abuse Death Review Committee or a local committee which reveals the identity of a deceased child whose death has been reported to the central abuse hotline but determined not to be the result of abuse or neglect, or the identity of the surviving siblings, family members, or others living in the home of such deceased child, is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(c) Information made confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution which is obtained by the State Child Abuse Death Review Committee or a local committee shall retain its confidential or exempt status.

(3)(a) Portions of meetings of the State Child Abuse Death Review Committee or a local committee at which information made confidential and exempt pursuant to subsection (2) is discussed are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution. The closed portion of a meeting must be recorded, and no portion of the closed meeting may be off the record. The recording shall be maintained by the State Child Abuse Death Review Committee or a local committee.

(b) The recording of a closed portion of a meeting is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(4) The State Child Abuse Death Review Committee and local committees may share information made confidential and exempt by this section:

(a) With each other;

(b) With a governmental agency in furtherance of its duties; or

(c) With any person or entity authorized by the Department of Health to use such relevant information for bona fide research or statistical purposes. A person or entity who is authorized to obtain such relevant information for research or statistical purposes must enter into a privacy and security agreement with the Department of Health and comply with all laws and rules governing the use of such records and information for research or statistical purposes. Anything identifying the subjects of such relevant information must be treated as confidential by the person or entity and may not be released in any form.

(5) Any person who knowingly or willfully makes public or discloses to any unauthorized person any information made confidential and exempt under this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(6) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2020, unless reviewed and saved from repeal through reenactment by the Legislature.

History.—s. 1, ch. 2005-190; s. 95, ch. 2008-4; s. 1, ch. 2010-40; s. 1, ch. 2015-77.

Appendix D

STATEMENT OF CONFIDENTIALITY

Name:

Date:

I understand the following:

The purpose of the Child Abuse Death Review Team is to conduct a full examination of the death incident.

No material will be taken from the meeting with case identifying information.

The confidentiality of the information and records is governed by applicable Florida law.

_____

(Signature)

_____

(Agency)

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APPENDIX E:

Case Report Form

The National Center for the REVIEW & PREVENTION OF CHILD DEATHS

Understanding How and Why Children Die & Taking Action to Prevent Child Deaths

Child Death Review Case Reporting System

Case Report - Version 4.0

Instructions:

This case report is used by Child Death Review (CDR) teams to enter data into the National CDR Case Reporting System. This system is available to states from the National Center for the Review & Prevention of Child Deaths and requires a data use agreement for state and local data entry. System functions include data entry, case report, editing and printing, data download and standardized reports.

The purpose of this form is to collect comprehensive information from multiple agencies participating in a child death review. The form documents demographics, the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and/or taken by the CDR team to prevent other deaths.

While this data collection form is an important part of the child death review process, the form should not be the central focus of the review meeting. Experienced users have found that it works best to assign a person to record data while the team discussions are occurring. Persons should not attempt to answer every single question in a step-by-step manner as part of the team discussion. The form can be partially filled out before a meeting.

It is not expected that teams will have answers to all of the questions related to a death. However, over time teams begin to understand the importance of data collection and bring the necessary information to the meeting. They find that the percentage of unknowns and unanswered questions decreases as the team becomes more familiar with the form.

The form contains three types of questions: (1) Those that users should only select one response as represented by a circle; (2) Those in which users can select multiple responses as represented by a square; and (3) Those in which users enter text. This last type is indicated by the words 'specify' or 'describe'.

Most questions have a selection for unknown (U/K). A question should be marked 'unknown' if an attempt was made to find the answer but no clear or satisfactory response was obtained. A question should be left blank (unanswered) if no attempt was made to find the answer. 'N/A' stands for 'Not Applicable' and should be used if the question is not applicable.

This edition is Version 4.0, effective January 2015. Additional paper forms can be ordered from the National Center at no charge. Users interested in participating in the web-based case reporting system for data entry and reporting should contact the National Center for the Review & Prevention of Child Deaths. This latest version incorporates the Sudden and Unexpected Infant Death (SUID) Case Registry and the Sudden Death in the Young (SDY) Case Registry questions.

Data entry website: https://cdrdata.org

Phone: 1-800-656-2434 Email: info@childdeathreview.org Website: www.childdeathreview.org

! Core information for data gathering. Every effort should be made to provide the information for these fields (when applicable to manner of death).

 If Available

 Need to define

New Section added in form Version 4

CASE NUMBER

_____/_____/_____/_____

State / County or Team Number / Year of Review / Sequence of Review

Case Type: ○ Death ○ Near death/serious injury ○ Not born alive

Death Certificate Number:

Birth Certificate Number:

ME/Coroner Number:

Date CDRT Notified of Death:

A. CHILD INFORMATION

1. Child's name: First: Middle: Last: ☐ U/K

2. Date of birth: ☐ U/K mm dd yyyy

3. Date of death: ☐ U/K mm dd yyyy

4. Age: ○ Years ○ Months ○ Days ○ Hours ○ Minutes ○ U/K

5. Race, check all that apply: ☐ U/K
☐ White ☐ Native Hawaiian
☐ Black ☐ Pacific Islander, specify:
☐ Asian, specify:
☐ American Indian, Tribe:
☐ Alaskan Native, Tribe:

6. Hispanic or Latino origin? ○ Yes ○ No ○ U/K

7. Sex: ○ Male ○ Female ○ U/K

8. Residence address: ☐ U/K
Street: Apt.
City:
State: Zip: County:

9. Type of residence:
○ Parental home ○ Relative home ○ Jail/detention
○ Licensed group home ○ Living on own ○ Other, specify:
○ Licensed foster home ○ Shelter
○ Relative foster home ○ Homeless ○ U/K

10. New residence in past 30 days? ○ Yes ○ No ○ U/K

11. Residence overcrowded? ○ Yes ○ No ○ U/K

12. Child ever homeless? ○ Yes ○ No ○ U/K

13. Number of other children living with child: _____ ☐ U/K

14. Child's weight: ☐ U/K
○ Pounds/ounces _____/_____
○ Grams/kilograms _____

15. Child's height: ☐ U/K
○ Feet/inches _____/_____
○ Cm _____

16. Highest education level:
○ N/A ○ Drop out
○ None ○ HS graduate
○ Preschool ○ College
○ Grade K-8 ○ Other, specify:
○ Grade 9-12 ○ U/K
○ Home schooled, K-8
○ Home schooled, 9-12

17. Child's work status:
○ N/A
○ Employed
○ Full time
○ Part time
○ U/K
○ Not working
○ U/K

18. Did child have problems in school? ○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Academic ☐ Behavioral
☐ Truancy ☐ Expulsion
☐ Suspensions ☐ U/K
☐ Other, specify:

19. Child's health insurance, check all that apply:
☐ None
☐ Private
☐ Medicaid
☐ State plan
☐ Other, specify:
☐ U/K

20. Child had disability or chronic illness? ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Physical/orthopedic, specify:
☐ Mental health/substance abuse, specify:
☐ Cognitive/intellectual, specify:
☐ Sensory, specify:
☐ U/K
If yes, was child receiving Children's Special Health Care Needs services? ○ Yes ○ No ○ U/K

21. Child's mental health (MH):
Child had received prior MH services? ○ N/A ○ Yes ○ No ○ U/K
Child was receiving MH services? ○ N/A ○ Yes ○ No ○ U/K
Child on medications for MH illness? ○ N/A ○ Yes ○ No ○ U/K
Issues prevented child from receiving MH services? ○ N/A ○ Yes ○ No ○ U/K
If yes, specify:

22. Child had history of substance abuse? ○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Alcohol ☐ Other, specify:
☐ Cocaine
☐ Marijuana ☐ U/K
☐ Methamphetamine
☐ Opiates
☐ Prescription drugs
☐ Over-the-counter drugs

23. Child had history of child maltreatment? If yes, check all that apply:

As Victim	As Perpetrator		As Victim	As Perpetrator
	○ N/A		☐	☐ Physical
○	○ Yes		☐	☐ Neglect
○	○ No		☐	☐ Sexual
○	○ U/K		☐	☐ Emotional/psychological
			☐	☐ U/K
○	○ Through CPS		_____	_____ # CPS referrals
○	○ Other sources		_____	_____ # Substantiations

If yes, how was history identified:

24. Was there an open CPS case with child at time of death? ○ Yes ○ No ○ U/K

25. Was child ever placed outside of the home prior to the death? ○ Yes ○ No ○ U/K

26. Were any siblings placed outside of the home prior to this child's death? ○ N/A ○ Yes, # _____ ○ No ○ U/K

27. Child had history of intimate partner violence? Check all that apply:
☐ N/A
☐ Yes, as victim
☐ Yes, as perpetrator
☐ No
☐ U/K

28. Child had delinquent or criminal history? ○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Assaults ☐ Other, specify:
☐ Robbery
☐ Drugs ☐ U/K

29. Child spent time in juvenile detention? ○ N/A ○ Yes ○ No ○ U/K

30. Child acutely ill during the two weeks before death? ○ Yes ○ No ○ U/K

31. Was any parent a first generation immigrant? ○ Yes ○ No ○ U/K
If yes, country of origin:

32. If child over age 12, what was child's gender identity?
○ Male
○ Female
○ U/K

33. If child over age 12, what was child's sexual orientation?
○ Heterosexual ○ Lesbian ○ Questioning
○ Gay ○ Bisexual ○ U/K

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

34. Gestational age: ☐ U/K
_____ # weeks

35. Birth weight: ☐ U/K
○ Grams/kilograms _____
○ Pounds/ounces _____/_____

36. Multiple birth?
○ Yes, # _____
○ No ○ U/K

37. Including the deceased infant, how many pregnancies did the birth mother have? #___ ☐ U/K

38. Including the deceased infant, how many live births did the birth mother have? #___ ☐ U/K

39. Not including the deceased infant, number of children birth mother still has living? #_____ ☐ U/K

40. Prenatal care provided during pregnancy of deceased infant? ○ Yes ○ No ○ U/K
If yes, number of prenatal visits: #_____ ☐ U/K
If yes, month of first prenatal visit: Specify 1-9 ___ ☐ U/K

41. During pregnancy, did mother (check all that apply):

Yes	No	U/K	
○	○	○	Have medical complications/infections?
○	○	○	Experience intimate partner violence?
○	○	○	Use illicit drugs?
		☐	Infant born drug exposed?
○	○	○	Misuse OTC or prescription drugs?
○	○	○	Have heavy alcohol use?
		☐	Infant born with fetal alcohol effects or syndrome?

If yes, medical complications/infections, check all that apply:

- ☐ Acute/chronic lung disease
- ☐ Anemia
- ☐ Cardiac disease
- ☐ Chorioamnionitis
- ☐ Chronic hypertension
- ☐ Diabetes
- ☐ Eclampsia
- ☐ Genital herpes
- ☐ Hemoglobinopathy
- ☐ High MSAFP
- ☐ Hydramnios/oligohydramnios
- ☐ Incompetent cervix
- ☐ Low MSAFP
- ☐ Other infectious disease
- ☐ Pregnancy-related hypertension
- ☐ Preterm labor
- ☐ Previous infant 4000+ grams
- ☐ Previous infant preterm/ small for gestation
- ☐ PROM
- ☐ Renal disease
- ☐ Rh sensitization
- ☐ Uterine bleeding
- ☐ Other, specify:

42. Were there access or compliance issues related to prenatal care? ○ Yes ○ No ○ U/K If yes, check all that apply:

- ☐ Lack of money for care
- ☐ Limitations of health insurance coverage
- ☐ Multiple health insurance, not coordinated
- ☐ Lack of transportation
- ☐ No phone
- ☐ Cultural differences
- ☐ Religious objections to care
- ☐ Language barriers
- ☐ Referrals not made
- ☐ Specialist needed, not available
- ☐ Multiple providers, not coordinated
- ☐ Lack of child care
- ☐ Lack of family/social support
- ☐ Services not available
- ☐ Distrust of health care system
- ☐ Unwilling to obtain care
- ☐ Intimate partner would not allow care
- ☐ Other, specify:
- ☐ U/K

43. Did mother smoke in the 3 months before pregnancy?
○ Yes
○ No
○ U/K
If yes, ___ Avg # cigarettes/day (20 cigarettes in pack)
☐ U/K quantity

44. Did mother smoke at any time during pregnancy?
○ Yes ○ No ○ U/K

If yes,	Trimester 1	Trimester 2	Trimester 3	
	_____	_____	_____	Avg # cigarettes/day (20 cigarettes in pack)
	☐	☐	☐	U/K quantity

45. Infant ever breastfed? ○ Yes ○ No ○ U/K

46. Was mother injured during pregnancy? ○ Yes ○ No ○ U/K
If yes, describe:

47. Did infant have abnormal metabolic newborn screening results? ○ Yes ○ No ○ U/K
If yes, was abnormality a fatty acid oxidation error, such as MCAD? ○ Yes ○ No ○ U/K
If yes, describe:
If other abnormalities, describe:

48. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply):

- ☐ Infection
- ☐ Allergies
- ☐ Abnormal growth, weight gain/loss
- ☐ Apnea
- ☐ Cyanosis
- ☐ Seizures or convulsions
- ☐ Cardiac abnormalities
- ☐ Metabolic disorders
- ☐ Other, specify:

49. In the 72 hours prior to death, did the infant have any of the following? Check all that apply:

- ☐ Fever
- ☐ Excessive sweating
- ☐ Lethargy/sleeping more than usual
- ☐ Fussiness/excessive crying
- ☐ Decrease in appetite
- ☐ Vomiting
- ☐ Choking
- ☐ Diarrhea
- ☐ Stool changes
- ☐ Difficulty breathing
- ☐ Apnea
- ☐ Cyanosis
- ☐ Seizures or convulsions
- ☐ Other, specify:

50. In the 72 hours prior to death, was the infant injured? ○ Yes ○ No ○ U/K
If yes, describe cause and injuries:

51. In the 72 hours prior to death, was the infant given any vaccines? ○ Yes ○ No ○ U/K
If yes, list name(s) of vaccines:

52. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription and over-the-counter medications and home remedies. ○ Yes ○ No ○ U/K
If yes, list name and last dose given:

53. What did the infant have for his/her last meal? Check all that apply:

- ☐ Breast milk
- ☐ Formula, type:
- ☐ Baby food, type:
- ☐ Cereal, type:
- ☐ Other, specify:
- ☐ U/K

B. PRIMARY CAREGIVER(S) INFORMATION

1. Primary caregiver(s): Select only one each in columns one and two.

One	Two	One	Two
○	Self, go to Section C	○	○ Grandparent
○	○ Biological parent	○	○ Sibling
○	○ Adoptive parent	○	○ Other relative
○	○ Stepparent	○	○ Friend
○	○ Foster parent	○	○ Institutional staff
○	○ Mother's partner	○	○ Other, specify:
○	○ Father's partner	○	○ U/K

2. Caregiver(s) age in years:

One	Two	
_____	_____	# Years
☐	☐	U/K

3. Caregiver(s) sex:

One	Two
○	○ Male
○	○ Female
○	○ U/K

4. Caregiver(s) employment status:

One	Two
○	○ Employed
○	○ Unemployed
○	○ On disability
○	○ Stay-at-home
○	○ Retired
○	○ U/K

5. Caregiver(s) income:

One	Two
○	○ High
○	○ Medium
○	○ Low
○	○ U/K

6. Caregiver(s) education:

One	Two
○	○ < High school
○	○ High school
○	○ College
○	○ Post graduate
○	○ U/K

7. Do caregiver(s) speak English?

One	Two
○	○ Yes
○	○ No
○	○ U/K

If no, language spoken:

8. Caregiver(s) on active military duty?

One	Two
○	○ Yes
○	○ No
○	○ U/K

If yes, specify branch:

9. Caregiver(s) receive social services in the past twelve months?

One	Two	
○	○ Yes	
○	○ No	
○	○ U/K	
☐	☐	WIC
☐	☐	TANF
☐	☐	Medicaid
☐	☐	Food stamps
☐	☐	Other, specify:
☐	☐	U/K

If yes, check all that apply

10. Caregiver(s) have substance abuse history?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

☐	☐	Alcohol
☐	☐	Cocaine
☐	☐	Marijuana
☐	☐	Methamphetamine
☐	☐	Opiates
☐	☐	Prescription drugs
☐	☐	Over-the-counter
☐	☐	Other, specify:
☐	☐	U/K

11. Caregiver(s) ever victim of child maltreatment?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

☐	☐	Physical
☐	☐	Neglect
☐	☐	Sexual
☐	☐	Emotional/psychological
☐	☐	U/K
_____	_____	# CPS referrals
_____	_____	# Substantiations
☐	☐	Ever in foster care or adopted

12. Caregiver(s) ever perpetrator of maltreatment?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

☐	☐	Physical
☐	☐	Neglect
☐	☐	Sexual
☐	☐	Emotional/psychological
☐	☐	U/K
_____	_____	# CPS referrals
_____	_____	# Substantiations
☐	☐	CPS prevention services
☐	☐	Family preservation services
☐	☐	Children ever removed

13. Caregiver(s) have disability or chronic illness?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

☐	☐	Physical, specify:
☐	☐	Mental, specify:
☐	☐	Sensory, specify:
☐	☐	U/K

If mental illness, was caregiver receiving MH services?

○	○	Yes
○	○	No
○	○	U/K

14. Caregiver(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, cause(s): Check all that apply:

One	Two	
☐	☐	Child abuse # _____
☐	☐	Child neglect # _____
☐	☐	Accident # _____
☐	☐	Suicide # _____
☐	☐	SIDS # _____
☐	☐	Other # _____
		Other, specify:
☐	☐	U/K

15. Caregiver(s) have history of intimate partner violence?

One	Two	
☐	☐	Yes, as victim
☐	☐	Yes, as perpetrator
☐	☐	No
☐	☐	U/K

16. Caregiver(s) have delinquent/criminal history?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

☐	☐	Assaults
☐	☐	Robbery
☐	☐	Drugs
☐	☐	Other, specify:
☐	☐	U/K

C. SUPERVISOR INFORMATION

1. Did child have supervision at time of incident leading to death?
○ Yes, answer 2-15
○ No, not needed given developmental age or circumstances, go to Sect. D
○ No, but needed, answer 3-15
○ Unable to determine, try to answer 3-15

2. How long before incident did supervisor last see child? Select one:
○ Child in sight of supervisor
○ Minutes _____ ○ Days _____
○ Hours _____ ○ U/K

3. Is person a primary caregiver as listed in previous section?
○ Yes, caregiver one, go to 15
○ Yes, caregiver two, go to 15
○ No

4. Primary person responsible for supervision? Select only one:

○ Biological parent	○ Foster parent	○ Grandparent	○ Friend	○ Institutional staff, go to 15	○ Other, specify:
○ Adoptive parent	○ Mother's partner	○ Sibling	○ Acquaintance	○ Babysitter	
○ Stepparent	○ Father's partner	○ Other relative	○ Hospital staff, go to 15	○ Licensed child care worker	○ U/K

5. Supervisor's age in years:
_____ ☐ U/K

6. Supervisor's sex:
○ Male ○ Female ○ U/K

7. Does supervisor speak English?
○ Yes ○ No ○ U/K
If no, language spoken:

8. Supervisor on active military duty?
○ Yes ○ No ○ U/K
If yes, specify branch:

9. Supervisor has substance abuse history?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Alcohol
☐ Cocaine
☐ Marijuana
☐ Methamphetamine
☐ Opiates
☐ Prescription drugs
☐ Over-the-counter
☐ Other, specify:
☐ U/K

10. Supervisor has history of child maltreatment?

As Victim	As Perpetrator	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

☐	☐	Physical
☐	☐	Neglect
☐	☐	Sexual
☐	☐	Emotional/psychological
☐	☐	U/K
_____	_____	# CPS referrals
_____	_____	# Substantiations
☐		Ever in foster care/adopted
	☐	CPS prevention services
	☐	Family preservation services
	☐	Children ever removed

11. Supervisor has disability or chronic illness?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Physical, specify:
☐ Mental, specify:
☐ Sensory, specify:
☐ U/K
If mental illness, was supervisor receiving MH services?
○ Yes
○ No
○ U/K

12. Supervisor has prior child deaths?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Child abuse # _____
☐ Child neglect # _____
☐ Accident # _____
☐ Suicide # _____
☐ SIDS # _____
☐ Other # _____
Other, specify:
☐ U/K

13. Supervisor has history of intimate partner violence?
- ☐ Yes, as victim
- ☐ Yes, as perpetrator
- ☐ No
- ☐ U/K

14. Supervisor has delinquent or criminal history? ○ Yes ○ No ○ U/K
If yes, check all that apply:
- ☐ Assaults ☐ Drugs ☐ U/K
- ☐ Robbery ☐ Other, specify:

15. At time of incident was supervisor impaired? ○ Yes ○ No ○ U/K
If yes, check all that apply:
- ☐ Drug impaired, specify:
- ☐ Alcohol impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Absent
- ☐ Impaired by illness, specify:
- ☐ Impaired by disability, specify:
- ☐ Other, specify:

D. INCIDENT INFORMATION

1. Date of incident event:
- ○ Same as date of death
- ○ If different than date of death: ___/___/___ (mm/dd/yyyy)
- ○ U/K

2. Approximate time of day that incident occurred?
Hour, specify 1-12 _____
○ AM ○ PM ○ U/K

3. Interval between incident and death: ☐ U/K
- ☐ Minutes ___ ☐ Hours ___ ☐ Days ___
- ☐ Weeks ___ ☐ Months ___ ☐ Years ___

4. Place of incident, check all that apply:
- ☐ Child's home
- ☐ Relative's home
- ☐ Friend's home
- ☐ Licensed foster care home
- ☐ Relative foster care home
- ☐ Licensed group home
- ☐ Licensed child care center
- ☐ Licensed child care home
- ☐ Unlicensed child care home
- ☐ Farm
- ☐ School
- ☐ Place of work
- ☐ Indian reservation
- ☐ Military installation
- ☐ Jail/detention facility
- ☐ Sidewalk
- ☐ Roadway
- ☐ Driveway
- ☐ Other parking area
- ☐ State or county park
- ☐ Sports area
- ☐ Other recreation area
- ☐ Hospital
- ☐ Other, specify:
- ☐ U/K

5. Type of area:
- ○ Urban
- ○ Suburban
- ○ Rural
- ○ Frontier
- ○ U/K

6. Incident state:

7. Incident county:

8. Death state:

9. Death county:

10. Was the incident witnessed? ○ Yes ○ No ○ UK
If yes, by whom?
- ☐ Parent/relative
- ☐ Other caretaker/babysitter
- ☐ Teacher/coach/athletic trainer
- ☐ Other acquaintance
- ☐ Health care professional, if death occurred in a hospital setting
- ☐ Stranger
- ☐ Other, specify:

11. Was 911 or local emergency called? ○ N/A ○ Yes ○ No ○ U/K

12. Was resuscitation attempted? ○ N/A ○ Yes ○ No ○ U/K
If yes, by whom?
- ☐ EMS
- ☐ Parent/relative
- ☐ Other caretaker/babysitter
- ☐ Teacher/coach/athletic trainer
- ☐ Other acquaintance
- ☐ Health care professional, if death occurred in a hospital setting
- ☐ Stranger
- ☐ Other, specify:

If yes, type of resuscitation:
- ☐ CPR
- Automated External Defibrillator (AED)
  - If no AED, was AED available/accessible? ○ Yes ○ No ○ U/K
  - If AED, was shock administered? ○ Yes ○ No ○ U/K
  - If yes, how many shocks were administered? _____
- ☐ Rescue medications, specify type:
- ☐ Other, specify:

If yes, was a rhythm recorded? ○ Yes ○ No ○ U/K
If yes, what was the rhythm? _____

13. At time of incident leading to death, had child used drugs or alcohol?
○ N/A ○ Yes ○ No ○ U/K

14. Child's activity at time of incident, check all that apply:
- ☐ Sleeping ☐ Working ☐ Driving/vehicle occupant ☐ U/K
- ☐ Playing ☐ Eating ☐ Other, specify:

15. Total number of deaths at incident event:
- ____ Children, ages 0-18 ○ U/K
- ____ Adults

E. INVESTIGATION INFORMATION

1. Death referred to:
- ○ Medical examiner
- ○ Coroner
- ○ Not referred
- ○ U/K

2. Person declaring official cause and manner of death:
- ○ Medical examiner
- ○ Coroner
- ○ Hospital physician
- ○ Other physician
- ○ Mortician
- ○ Other, specify:
- ○ U/K

3. Autopsy performed? ○ Yes ○ No ○ U/K
If yes, conducted by:
- ○ Forensic pathologist
- ○ Pediatric pathologist
- ○ General pathologist
- ○ Unknown pathologist
- ○ Other physician
- ○ Other, specify:
- ○ U/K

If no, why not (e.g. parent or caregiver objected)?

If autopsy performed, was a specialist consulted during autopsy (cardiac, neurology, etc.)? ○ Yes ○ No ○ U/K If yes, specify specialist:

4. Were the following assessed either through the autopsy or through information collected prior to the autopsy:

Y	N	U/K	Abnormal?	
Imaging:				
○	○	○	☐	X-ray - single
○	○	○	☐	X-ray - multiple views
○	○	○	☐	X-ray - complete skeletal series
○	○	○	☐	CT scan
○	○	○	☐	MRI
○	○	○	☐	Photography of the brain
External Exam:				
○	○	○	☐	Exam of general appearance
○	○	○	☐	Head circumference
Gross Examination of:				
○	○	○	☐	Body cavities
○	○	○	☐	Brain
○	○	○	☐	Endocrine organs
○	○	○	☐	Gastrointestinal tract
○	○	○	☐	Heart
○	○	○	☐	Kidneys
○	○	○	☐	Liver

Y	N	U/K	Abnormal?	
Gross Examination continued:				
○	○	○	☐	Lungs
○	○	○	☐	Neck structures
○	○	○	☐	Pancreas
○	○	○	☐	Spleen
○	○	○	☐	Thymus
In situ exam with removal & dissection of:				
○	○	○	☐	Brain
○	○	○	☐	Endocrine organs
○	○	○	☐	Gastrointestinal tract
○	○	○	☐	Heart
○	○	○	☐	Kidneys
○	○	○	☐	Liver
○	○	○	☐	Lungs
○	○	○	☐	Neck structures
○	○	○	☐	Pancreas
○	○	○	☐	Spleen
○	○	○	☐	Thymus

Y	N	U/K	Abnormal?	
Weights of the:				
○	○	○	☐	Brain
○	○	○	☐	Heart
○	○	○	☐	Kidneys
○	○	○	☐	Liver
○	○	○	☐	Lungs
○	○	○	☐	Neck structures
○	○	○	☐	Pancreas
○	○	○	☐	Spleen
○	○	○	☐	Thymus

4. Continued: Were the following assessed either through the autopsy or through information collected prior to the autopsy:

Sampled tissue of:	Y	N	U/K	Abnormal?
Airway	○	○	○	☐
Bone or costochondral tissue	○	○	○	☐
Brain or meninges	○	○	○	☐
Endocrine organs	○	○	○	☐
Gastrointestinal tract	○	○	○	☐
Heart	○	○	○	☐
Kidneys	○	○	○	☐
Liver	○	○	○	☐
Lungs	○	○	○	☐
Neck structures	○	○	○	☐
Pancreas	○	○	○	☐
Spleen	○	○	○	☐
Thymus	○	○	○	☐

Microscopic/Histological exam of:	Y	N	U/K	Abnormal?
Airway	○	○	○	☐
Bone or costochondral tissue	○	○	○	☐
Brain or meninges	○	○	○	☐
Endocrine organs	○	○	○	☐
Gastrointestinal tract	○	○	○	☐
Heart	○	○	○	☐
Kidneys	○	○	○	☐
Liver	○	○	○	☐
Lungs	○	○	○	☐
Neck structures	○	○	○	☐
Pancreas	○	○	○	☐
Spleen	○	○	○	☐
Thymus	○	○	○	☐

Additional Testing:	Y	N	U/K	Abnormal?
Cultures for infectious disease	○	○	○	☐
Microbiology	○	○	○	☐
Postmortem metabolic screen	○	○	○	☐
Vitreous testing as an adjunct to other investigation results	○	○	○	☐
Genetic testing	○	○	○	☐

Toxicology:

○ ○ ○ ☐ Toxicology If yes, check all that apply:

☐ Negative ☐ Opiates
☐ Alcohol ☐ Too high Rx drug, specify:
☐ Cocaine ☐ Too high OTC drug, specify:
☐ Marijuana ☐ Other, specify:
☐ Methamphetamine ☐ U/K

5. Was the child's medical history reviewed as part of the autopsy? ○ Yes ○ No ○ U/K
If yes, did this include:
Review of the newborn metabolic screen results? ○ Yes ○ No ○ U/K ○ Not Performed
Review of neonatal CCHD screen results? ○ Yes ○ No ○ U/K ○ Not Performed

6. Describe any abnormalities checked in E4 or E5 or other significant findings noted in the autopsy:

7. Was there agreement between the cause of death listed on the pathology report and on the death certificate? ○ Yes ○ No ○ U/K
If no, describe the differences:

8. Was a death scene investigation performed? ○ Yes ○ No ○ U/K
If yes, which of the following death scene investigation components were completed?

	Yes	No	U/K		Yes	No
CDC's SUIDI Reporting Form or jurisdictional equivalent	○	○	○	If yes, shared with CDR team?	○	○
Narrative description of circumstances	○	○	○	If yes, shared with CDR team?	○	○
Scene photos	○	○	○	If yes, shared with CDR team?	○	○
Scene recreation with doll	○	○	○	If yes, shared with CDR team?	○	○
Scene recreation without doll	○	○	○	If yes, shared with CDR team?	○	○
Witness interviews	○	○	○	If yes, shared with CDR team?	○	○

9. Agencies that conducted a scene investigation, check all that apply:

☐ Medical examiner ☐ Fire investigator
☐ Coroner ☐ EMS
☐ ME investigator ☐ Child Protective Services
☐ Coroner investigator ☐ Other, specify:
☐ Law enforcement
☐ U/K

10. Was a CPS record check conducted as a result of death? ○ Yes ○ No ○ U/K

11. Did any investigation find evidence of prior abuse? ○ N/A ○ Yes ○ No ○ U/K
If yes, from what source?
Check all that apply:
☐ From x-rays ☐ U/K
☐ From autopsy
☐ From CPS review
☐ From law enforcement

12. CPS action taken because of death? ○ N/A ○ Yes ○ No ○ U/K
If yes, highest level of action taken because of death:
○ Report screened out and not investigated
○ Unsubstantiated
○ Inconclusive
○ Substantiated

If yes, services or actions resulting, check all that apply:
☐ Voluntary services offered
☐ Voluntary services provided
☐ Court-ordered services provided
☐ Voluntary out of home placement
☐ Court-ordered out of home placement
☐ Children removed
☐ Parental rights terminated
☐ U/K

13. If death occurred in licensed setting (see D4), indicate action taken:
○ No action
○ License suspended
○ License revoked
○ Investigation ongoing
○ Other, specify:
○ U/K

F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

1. Enter the cause of death code (ICD-10) assigned to this case by Vital Records using a capital letter and corresponding number (e.g., W75 or V94.4) and include up to one decimal place if applicable: _____ ☐ U/K

2. Enter the following information exactly as written on the death certificate: ☐ U/K

Immediate cause (final disease or condition resulting in death):

a.

Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death:

b.

c.

d.

3. Enter other significant conditions contributing to death but not the underlying cause(s) listed in F2 exactly as written on the death certificate: ☐ U/K

4. If injury, describe how injury occurred exactly as written on the death certificate: ☐ U/K

5. Official manner of death from the death certificate:

- ○ Natural
- ○ Accident
- ○ Suicide
- ○ Homicide
- ○ Undetermined
- ○ Pending
- ○ U/K

If Homicide: Yes
Child abuse? ☐
Child neglect? ☐
Complete Section I, Acts of Omission or Commission

If Suicide: Complete Section I, Acts of Omission or Commission

6. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.

○ From an injury (external cause). Select one and answer F4:
- ○ Motor vehicle and other transport, go to G1
- ○ Fire, burn, or electrocution, go to G2
- ○ Drowning, go to G3
- ○ Asphyxia, go to G4
- ○ Weapon, including body part, go to G5
- ○ Animal bite or attack, go to G6
- ○ Fall or crush, go to G7
- ○ Poisoning, overdose or acute intoxication, go to G8
- ○ Exposure, go to G9
- ○ Undetermined, go to H1
- ○ Other cause, go to G11
- ○ U/K, go to H1

○ From a medical cause. Select one:
- ○ Asthma, go to G10
- ○ Cancer, specify and go to G10
- ○ Cardiovascular, specify and go to G10
- ○ Congenital anomaly, specify and go to G10
- ○ Diabetes, go to G10
- ○ HIV/AIDS, go to G10
- ○ Influenza, go to G10
- ○ Low birth weight, go to G10
- ○ Malnutrition/dehydration, go to G10
- ○ Neurological/seizure disorder, go to G10
- ○ Pneumonia, specify and go to G10
- ○ Prematurity, go to G10
- ○ SIDS, go to G10
- ○ Other infection, specify and go to G10
- ○ Other perinatal condition, specify and go to G10
- ○ Other medical condition, specify and go to G10
- ○ Undetermined, go to G10
- ○ U/K, go to G10

○ Undetermined if injury or medical cause, go to H1

○ U/K go to H1

G. DETAILED INFORMATION BY *CAUSE* OF DEATH: CHOOSE ONE SECTION ONLY, THAT IS SAME AS THE CAUSE SELECTED ABOVE

1. MOTOR VEHICLE AND OTHER TRANSPORT

a. Vehicles involved in incident:
Total number of vehicles: _____

Child's	Other primary vehicle	
○	○	None
○	○	Car
○	○	Van
○	○	Sport utility vehicle
○	○	Truck
○	○	Semi/tractor trailer
○	○	RV
○	○	School bus
○	○	Other bus
○	○	Motorcycle
○	○	Tractor
○	○	Other farm vehicle
○	○	All terrain vehicle
○	○	Snowmobile
○	○	Bicycle
○	○	Train
○	○	Subway
○	○	Trolley
○	○	Other, specify:
○	○	U/K

b. Position of child:
- ○ Driver
- ○ Passenger
  - If passenger, relationship of driver to child:
    - ○ Front seat
    - ○ Back seat
    - ○ Truck bed
    - ○ Other, specify:
    - ○ U/K
    - ○ Biological parent
    - ○ Adoptive parent
    - ○ Stepparent
    - ○ Foster parent
    - ○ Mother's partner
    - ○ Father's partner
    - ○ Grandparent
    - ○ Sibling
    - ○ Other relative
    - ○ Friend
    - ○ Other, specify:
    - ○ U/K
- ○ On bicycle
- ○ Pedestrian
  - ○ Walking
  - ○ Boarding/blading
  - ○ Other, specify:
  - ○ U/K
- ○ U/K

c. Causes of incident, check all that apply:
- ☐ Speeding over limit
- ☐ Unsafe speed for conditions
- ☐ Recklessness
- ☐ Ran stop sign or red light
- ☐ Driver distraction
- ☐ Driver inexperience
- ☐ Mechanical failure
- ☐ Poor tires
- ☐ Poor weather
- ☐ Poor visibility
- ☐ Drugs or alcohol use
- ☐ Fatigue/sleeping
- ☐ Medical event, specify:
- ☐ Back/front over
- ☐ Flipover
- ☐ Poor sight line
- ☐ Car changing lanes
- ☐ Road hazard
- ☐ Animal in road
- ☐ Cell phone use while driving
- ☐ Racing, not authorized
- ☐ Other driver error, specify:
- ☐ Other, specify:
- ☐ U/K

d. Collision type:
- ○ Child *not* in/on a vehicle, but struck by vehicle
- ○ Child in/on a vehicle, struck by other vehicle
- ○ Child in/on a vehicle that struck other vehicle
- ○ Child in/on a vehicle that struck person/object
- ○ Other event, specify:
- ○ U/K

e. Driving conditions, check all that apply:
- ☐ Normal
- ☐ Loose gravel
- ☐ Muddy
- ☐ Ice/snow
- ☐ Fog
- ☐ Wet
- ☐ Construction zone
- ☐ Inadequate lighting
- ☐ Other, specify:
- ☐ U/K

f. Location of incident, check all that apply:
- ☐ City street
- ☐ Residential street
- ☐ Rural road
- ☐ Highway
- ☐ Intersection
- ☐ Shoulder
- ☐ Sidewalk
- ☐ Driveway
- ☐ Parking area
- ☐ Off road
- ☐ RR xing/tracks
- ☐ Other, specify:
- ☐ U/K

g. Drivers involved in incident, check all that apply:

Child as driver	Child's driver	Driver of other primary vehicle		Child as driver	Child's driver	Driver of other primary vehicle	
	Age of Driver	Age of Driver					Has a graduated license
	○	○	<16 years				Has a full license
	○	○	16 to 18 years old				Has a full license that has been restricted
	○	○	19 to 21 years old				Has a suspended license
	○	○	22 to 29 years old				If recreational vehicle, has driver safety certificate
	○	○	30 to 65 years old				Other, specify:
	○	○	>65 years old				Was violating graduated licensing rules:
	○	○	U/K age				Nighttime driving curfew
☐	☐	☐	Responsible for causing incident				Passenger restrictions
☐	☐	☐	Was alcohol/drug impaired				Driving without required supervision
☐	☐	☐	Has no license				Other violations, specify:
☐	☐	☐	Has a learner's permit				U/K

h. Total number of occupants in vehicles:

In child's vehicle, including child:

☐ N/A, child was not in a vehicle

Total number of occupants: _____ ☐ U/K

Number of teens, ages 14-21: _____ ☐ U/K

Total number of deaths: _____ ☐ U/K

Total number of teen deaths: _____ ☐ U/K

In other primary vehicle involved in incident:

☐ N/A, incident was a single vehicle crash

Total number of occupants: _____ ☐ U/K

Number of teens, ages 14-21: _____ ☐ U/K

Total number of deaths: _____ ☐ U/K

Total number of teen deaths: _____ ☐ U/K

i. Protective measures for child, Select one option per row:

	Not Needed	Needed, none present	Present, used correctly	Present, used incorrectly	Present, not used	U/K
Airbag	○	○	○	○	○	○
Lap belt	○	○	○	○	○	○
Shoulder belt	○	○	○	○	○	○
Child seat*	○	○	○	○	○	○
Belt positioning booster seat	○	○	○	○	○	○
Helmet	○	○	○	○	○	○
Other, specify:	○	○	○	○	○	○

*If child seat, type:
○ Rear facing
○ Front facing
○ U/K

2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source:

○ Matches	○ Heating stove	○ Lightning	○ Other explosives
○ Cigarette lighter	○ Space heater	○ Oxygen tank	○ Appliance in water
○ Utility lighter	○ Furnace	○ Hot cooking water	○ Other, specify:
○ Cigarette or cigar	○ Power line	○ Hot bath water	
○ Candles	○ Electrical outlet	○ Other hot liquid, specify:	
○ Cooking stove	○ Electrical wiring	○ Fireworks	○ U/K

b. Type of incident:
○ Fire, go to c
○ Scald, go to r
○ Other burn, go to t
○ Electrocution, go to s
○ Other, specify and go to t
○ U/K, go to t

c. For fire, child died from:
○ Burns
○ Smoke inhalation
○ Other, specify:
○ U/K

d. Material first ignited:
○ Upholstery
○ Mattress
○ Christmas tree
○ Clothing
○ Curtain
○ Other, specify:
○ U/K

e. Type of building on fire:
○ N/A
○ Single home
○ Duplex
○ Apartment
○ Trailer/mobile home
○ Other, specify:
○ U/K

f. Building's primary construction material:
○ Wood
○ Steel
○ Brick/stone
○ Aluminum
○ Other, specify:
○ U/K

g. Fire started by a person? ○ Yes ○ No ○ U/K

If yes, person's age _____

Does person have a history of setting fires? ○ Yes ○ No ○ U/K

h. Did anyone attempt to put out fire? ○ Yes ○ No ○ U/K

i. Did escape or rescue efforts worsen fire? ○ Yes ○ No ○ U/K

j. Did any factors delay fire department arrival? ○ Yes ○ No ○ U/K

If yes, specify:

k. Were barriers preventing safe exit? ○ Yes ○ No ○ U/K

If yes, check all that apply:
☐ Locked door
☐ Window grate
☐ Locked window
☐ Blocked stairway
☐ Other, specify:
☐ U/K

l. Was building a rental property? ○ Yes ○ No ○ U/K

m. Were building/rental codes violated? ○ Yes ○ No ○ U/K

If yes, describe in narrative.

n. Were proper working fire extinguishers present? ○ Yes ○ No ○ U/K

o. Was sprinkler system present? ○ Yes ○ No ○ U/K

If yes, was it working? ○ Yes ○ No ○ U/K

p. Were smoke detectors present? ○ Yes ○ No ○ U/K

If yes, what type?	If yes, functioning properly?	If not functioning properly, reason: Missing batteries	Other	U/K
☐ Removable batteries	○ Yes ○ No ○ U/K	☐	☐	☐
☐ Non-removable batteries	○ Yes ○ No ○ U/K		☐	☐
☐ Hardwired	○ Yes ○ No ○ U/K	☐	☐	☐
☐ U/K	○ Yes ○ No ○ U/K	☐	☐	☐

Other, specify:

If yes, was there an adequate number present? ○ Yes ○ No ○ U/K

q. Suspected arson?
○ Yes ○ No ○ U/K

r. For scald, was hot water heater set too high?
○ N/A
○ Yes, temp. setting: ____
○ No
○ U/K

s. For electrocution, what cause:
○ Electrical storm
○ Faulty wiring
○ Wire/product in water
○ Child playing with outlet
○ Other, specify:
○ U/K

t. Other, describe in detail:

3. DROWNING

a. Where was child last seen before drowning? Check all that apply:
☐ In water ☐ In yard
☐ On shore ☐ In bathroom
☐ On dock ☐ In house
☐ Poolside ☐ Other, specify:
☐ U/K

b. What was child last seen doing before drowning?
○ Playing ○ Tubing
○ Boating ○ Waterskiing
○ Swimming ○ Sleeping
○ Bathing ○ Other, specify:
○ Fishing
○ Surfing ○ U/K

c. Was child forcibly submerged?
○ Yes ○ No ○ U/K

d. Drowning location:
○ Open water, go to e ○ U/K, go to n
○ Pool, hot tub, spa, go to i
○ Bathtub, go to w
○ Bucket, go to x
○ Well/cistern/septic, go to n
○ Toilet, go to z
○ Other, specify and go to n

e. For open water, place:
○ Lake ○ Quarry
○ River ○ Gravel pit
○ Pond ○ Canal
○ Creek ○ U/K
○ Ocean

f. For open water, contributing environmental factors:
○ Weather ○ Drop off
○ Temperature ○ Rough waves
○ Current ○ Other, specify:
○ Riptide/ undertow ○ U/K

g. If boating, type of boat:
○ Sailboat ○ Commercial
○ Jet ski ○ Other, specify:
○ Motorboat
○ Canoe
○ Kayak ○ U/K
○ Raft

h. For boating, was the child piloting boat?
○ Yes ○ No ○ U/K

i. For pool, type of pool:
○ Above ground
○ In-ground ○ Hot tub, spa
○ Wading ○ U/K

j. For pool, child found:
○ In the pool/hot tub/spa
○ On or under the cover
○ U/K

k. For pool, ownership is:
○ Private
○ Public
○ U/K

l. Length of time owners had pool/hot tub/spa:
○ N/A ○ >1yr
○ <6 months ○ U/K
○ 6m-1 yr

m. Flotation device used?
○ N/A
○ Yes
○ No
○ U/K

If yes, check all that apply:
☐ Coast Guard approved ☐ Not Coast Guard approved ☐ U/K
☐ Jacket ☐ Cushion ☐ Lifesaving ring
If jacket:
Correct size? ○ Yes ○ No ○ U/K
Worn correctly? ○ Yes ○ No ○ U/K
☐ Swim rings
☐ Inner tube
☐ Air mattress
☐ Other, specify:

n. What barriers/layers of protection existed to prevent access to water?
Check all that apply:
☐ None ☐ Alarm, go to r
☐ Fence, go to o ☐ Cover, go to s
☐ Gate, go to p ☐ U/K
☐ Door, go to q

o. Fence:
Describe type:
Fence height in ft ____
Fence surrounds water on:
○ Four sides ○ Two or less sides
○ Three sides
○ U/K

p. Gate, check all that apply:
☐ Has self-closing latch
☐ Has lock
☐ Is a double gate
☐ Opens to water
☐ U/K

q. Door, check all that apply:
☐ Patio door ☐ Opens to water
☐ Screen door ☐ Barrier between door and water
☐ Steel door
☐ Self-closing ☐ U/K
☐ Has lock

r. Alarm, check all that apply:
☐ Door
☐ Window
☐ Pool
☐ Laser
☐ U/K

s. Type of cover:
○ Hard
○ Soft
○ U/K

t. Local ordinance(s) regulating access to water?
○ Yes ○ No ○ U/K

If yes, rules violated?
○ Yes ○ No ○ U/K

u. How were layers of protection breached? Check all that apply:
☐ No layers breached ☐ Gap in fence ☐ Door screen torn ☐ Cover left off
☐ Gate left open ☐ Damaged fence ☐ Door self-closer failed ☐ Cover not locked
☐ Gate unlocked ☐ Fence too short ☐ Window left open ☐ Other, specify:
☐ Gate latch failed ☐ Door left open ☐ Window screen torn
☐ Gap in gate ☐ Door unlocked ☐ Alarm not working
☐ Climbed fence ☐ Door broken ☐ Alarm not answered ☐ U/K

v. Child able to swim?
○ N/A ○ No
○ Yes ○ U/K

w. For bathtub, child in a bathing aid?
○ Yes ○ No ○ U/K
If yes, specify type:

x. Warning sign or label posted?
○ N/A ○ No
○ Yes ○ U/K

y. Lifeguard present?
○ N/A ○ No
○ Yes ○ U/K

z. Rescue attempt made?
○ N/A
○ Yes
○ No
○ U/K

If yes, who? Check all that apply:
☐ Parent ☐ Bystander
☐ Other child ☐ Other, specify:
☐ Lifeguard ☐ U/K

aa. Did rescuer(s) also drown?
○ N/A ○ No
○ Yes ○ U/K
If yes, number of rescuers that drowned: _____

bb. Appropriate rescue equipment present?
○ N/A ○ No
○ Yes ○ U/K

4. ASPHYXIA

a. Type of event:
- ○ Suffocation, go to b
- ○ Strangulation, go to c
- ○ Choking, go to d
- ○ Other, specify and go to e
- ○ U/K, go to e

b. If suffocation/asphyxia, action causing event:
- ○ Sleep-related (e.g. bedding, overlay, wedged)
- ○ Covered in or fell into object, but not sleep-related
  - ○ Plastic bag
  - ○ Dirt/sand
  - ○ Other, specify:
  - ○ U/K
- ○ Confined in tight space
  - ○ Refrigerator/freezer
  - ○ Toy chest
  - ○ Automobile
    - ○ Trunk
    - ○ Other, specify:
    - ○ U/K
  - ○ Other, specify:
  - ○ U/K
- ○ Swaddled in tight blanket, but not sleep-related
- ○ Wedged into tight space, but not sleep-related
- ○ Asphyxia by gas, go to G8h
- ○ Other, specify:
- ○ U/K

c. If strangulation, object causing event:
- ○ Clothing
- ○ Blind cord
- ○ Car seat
- ○ Stroller
- ○ High chair
- ○ Belt
- ○ Rope/string
- ○ Leash
- ○ Electrical cord
- ○ Person, go to G5q
- ○ Automobile power window or sunroof
- ○ Other, specify:
- ○ U/K

d. If choking, object causing choking:
- ○ Food, specify:
- ○ Toy, specify:
- ○ Balloon
- ○ Other, specify:
- ○ U/K

e. Was asphyxia an autoerotic event? ○ Yes ○ No ○ U/K

f. Was child participating in 'choking game' or 'pass out game'? ○ Yes ○ No ○ U/K

g. History of seizures? ○ Yes ○ No ○ U/K If yes, #____
If yes, witnessed? ○ Yes ○ No ○ U/K

h. History of apnea? ○ Yes ○ No ○ U/K If yes, #____
If yes, witnessed? ○ Yes ○ No ○ U/K

i. Was Heimlich Maneuver attempted? ○ Yes ○ No ○ U/K

5. WEAPON, INCLUDING PERSON'S BODY PART

a. Type of weapon:
- ○ Firearm, go to b
- ○ Sharp instrument, go to j
- ○ Blunt instrument, go to k
- ○ Person's body part, go to l
- ○ Explosive, go to m
- ○ Rope, go to m
- ○ Pipe, go to m
- ○ Biological, go to m
- ○ Other, specify and go to m
- ○ U/K, go to m

b. For firearms, type:
- ○ Handgun
- ○ Shotgun
- ○ BB gun
- ○ Hunting rifle
- ○ Assault rifle
- ○ Air rifle
- ○ Sawed off shotgun
- ○ Other, specify:
- ○ U/K

c. Firearm licensed? ○ Yes ○ No ○ U/K

d. Firearm safety features, check all that apply:
- ☐ Trigger lock
- ☐ Personalization device
- ☐ External safety/drop safety
- ☐ Loaded chamber indicator
- ☐ Magazine disconnect
- ☐ Minimum trigger pull
- ☐ Other, specify:
- ☐ U/K

e. Where was firearm stored?
- ○ Not stored
- ○ Locked cabinet
- ○ Unlocked cabinet
- ○ Glove compartment
- ○ Under mattress/pillow
- ○ Other, specify:
- ○ U/K

f. Firearm stored with ammunition? ○ Yes ○ No ○ U/K

g. Firearm stored loaded? ○ Yes ○ No ○ U/K

h. Owner of fatal firearm:
- ○ U/K, weapon stolen
- ○ U/K, weapon found
- ○ Self
- ○ Biological parent
- ○ Adoptive parent
- ○ Stepparent
- ○ Foster parent
- ○ Mother's partner
- ○ Father's partner
- ○ Grandparent
- ○ Sibling
- ○ Spouse
- ○ Other relative
- ○ Child's boyfriend or girlfriend
- ○ Classmate
- ○ Co-worker
- ○ Institutional staff
- ○ Neighbor
- ○ Rival gang member
- ○ Stranger
- ○ Law enforcement
- ○ Other, specify:
- ○ U/K

i. Sex of fatal firearm owner:
- ○ Male
- ○ Female
- ○ U/K

j. Type of sharp object:
- ○ Kitchen knife
- ○ Switchblade
- ○ Pocketknife
- ○ Razor
- ○ Hunting knife
- ○ Scissors
- ○ Other, specify:
- ○ U/K

k. Type of blunt object:
- ○ Bat
- ○ Club
- ○ Stick
- ○ Hammer
- ○ Rock
- ○ Household item
- ○ Other, specify:
- ○ U/K

l. What did person's body part do? Check all that apply:
- ☐ Beat, kick or punch
- ☐ Drop
- ☐ Push
- ☐ Bite
- ☐ Shake
- ☐ Strangle
- ☐ Throw
- ☐ Drown
- ☐ Burn
- ☐ Other, specify:
- ☐ U/K

m. Did person using weapon have history of weapon-related offenses?
- ○ Yes
- ○ No
- ○ U/K

n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?
- ○ Yes, describe circumstances:
- ○ No
- ○ U/K

o. Persons handling weapons at time of incident, check all that apply:

Fatal and/or Other weapon		Fatal and/or Other weapon	
☐	☐ Self	☐	☐ Friend
☐	☐ Biological parent	☐	☐ Acquaintance
☐	☐ Adoptive parent	☐	☐ Child's boyfriend or girlfriend
☐	☐ Stepparent	☐	☐ Classmate
☐	☐ Foster parent	☐	☐ Co-worker
☐	☐ Mother's partner	☐	☐ Institutional staff
☐	☐ Father's partner	☐	☐ Neighbor
☐	☐ Grandparent	☐	☐ Rival gang member
☐	☐ Sibling	☐	☐ Stranger
☐	☐ Spouse	☐	☐ Law enforcement officer
☐	☐ Other relative	☐	☐ Other, specify:
		☐	☐ U/K

p. Sex of person(s) handling weapon:

Fatal weapon:
- ○ Male
- ○ Female
- ○ U/K

Other weapon:
- ○ Male
- ○ Female
- ○ U/K

q. Use of weapon at time, check all that apply:

- ☐ Self injury
- ☐ Commission of crime
- ☐ Drive-by shooting
- ☐ Random violence
- ☐ Child was a bystander
- ☐ Argument
- ☐ Jealousy
- ☐ Intimate partner violence
- ☐ Hate crime
- ☐ Bullying
- ☐ Hunting
- ☐ Target shooting
- ☐ Playing with weapon
- ☐ Weapon mistaken for toy
- ☐ Showing gun to others
- ☐ Russian roulette
- ☐ Gang-related activity
- ☐ Self-defense
- ☐ Cleaning weapon
- ☐ Loading weapon
- ☐ Intervener assisting crime victim (Good Samaritan)
- ☐ Other, specify:
- ☐ U/K

6. ANIMAL BITE OR ATTACK

a. Type of animal:

- ○ Domesticated dog
- ○ Domesticated cat
- ○ Snake
- ○ Wild mammal, specify:
- ○ Insect
- ○ Other, specify:
- ○ U/K

b. Animal access to child, check all that apply:

- ☐ Animal on leash
- ☐ Animal caged or inside fence
  - ○ Child reached in
  - ○ Child entered animal area
  - ○ U/K
- ☐ Animal escaped from cage or leash
- ☐ Animal not caged or leashed
- ☐ U/K

c. Did child provoke animal? ○ Yes ○ No ○ U/K

If yes, how?

d. Animal has history of biting or attacking? ○ Yes ○ No ○ U/K

7. FALL OR CRUSH

a. Type:

- ○ Fall, go to b
- ○ Crush, go to h

b. Height of fall: _____ feet _____ inches

☐ U/K

c. Child fell from:

- ○ Open window
  - Screen?: ○ Screen ○ No screen ○ U/K if screen
- ○ Natural elevation
- ○ Man-made elevation
- ○ Playground equipment
- ○ Tree
- ○ Stairs/steps
- ○ Furniture
- ○ Bed
- ○ Roof
- ○ Moving object, specify:
- ○ Bridge
- ○ Overpass
- ○ Balcony
- ○ Animal, specify:
- ○ Other, specify:
- ○ U/K

d. Surface child fell onto:

- ○ Cement/concrete
- ○ Grass
- ○ Gravel
- ○ Wood floor
- ○ Carpeted floor
- ○ Linoleum/vinyl
- ○ Marble/tile
- ○ Other, specify:
- ○ U/K

e. Barrier in place: Check all that apply:

- ☐ None
- ☐ Screen
- ☐ Other window guard
- ☐ Fence
- ☐ Railing
- ☐ Stairway
- ☐ Gate
- ☐ Other, specify:
- ☐ U/K

f. Child in a baby walker?

- ○ N/A
- ○ Yes
- ○ No
- ○ U/K

g. Was child pushed, dropped or thrown? ○ Yes ○ No ○ U/K

If yes, go to G5q

h. For crush, did child:

- ○ Climb up on object
- ○ Pull object down
- ○ Hide behind object
- ○ Go behind object
- ○ Fall out of object
- ○ Other, specify:
- ○ U/K

i. For crush, object causing crush:

- ○ Appliance
- ○ Television
- ○ Furniture
- ○ Walls
- ○ Playground equipment
- ○ Animal
- ○ Tree branch
- ○ Boulders/rocks
- ○ Dirt/sand
- ○ Person, go to G5q
- ○ Commercial equipment
- ○ Farm equipment
- ○ Other, specify:
- ○ U/K

8. POISONING, OVERDOSE OR ACUTE INTOXICATION

a. Type of substance involved, check all that apply:

Prescription drug

- ☐ Antidepressant
- ☐ Blood pressure medication
- ☐ Pain killer (opiate)
- ☐ Pain killer (non-opiate)
- ☐ Methadone
- ☐ Cardiac medication
- ☐ Other, specify:

Over-the-counter drug

- ☐ Diet pills
- ☐ Stimulants
- ☐ Cough medicine
- ☐ Pain medication
- ☐ Children's vitamins
- ☐ Iron supplement
- ☐ Other vitamins
- ☐ Other, specify:
- ☐ Cosmetics/personal care products

Cleaning substances

- ☐ Bleach
- ☐ Drain cleaner
- ☐ Alkaline-based cleaner
- ☐ Solvent
- ☐ Other, specify:

Other substances

- ☐ Plants
- ☐ Alcohol
- ☐ Street drugs
- ☐ Pesticide
- ☐ Antifreeze
- ☐ Other chemical
- ☐ Herbal remedy
- ☐ Carbon monoxide, go to f
- ☐ Other fume/gas/vapor
- ☐ Other, specify:

☐ U/K

b. Where was the substance stored?

- ○ Open area
- ○ Open cabinet
- ○ Closed cabinet, unlocked
- ○ Closed cabinet, locked
- ○ Other, specify:
- ○ U/K

c. Was the product in its original container? ○ N/A ○ No ○ Yes ○ U/K

d. Did container have a child safety cap? ○ N/A ○ No ○ Yes ○ U/K

e. If prescription, was it child's? ○ Yes ○ No ○ U/K

f. Was the incident the result of?

- ○ Accidental overdose
- ○ Medical treatment mishap
- ○ Adverse effect, but not overdose
- ○ Deliberate poisoning
- ○ Acute intoxication
- ○ Other, specify:
- ○ U/K

g. Was Poison Control called? ○ Yes ○ No ○ U/K

If yes, who called:

- ○ Child
- ○ Parent
- ○ Other caregiver
- ○ First responder
- ○ Medical person
- ○ Other, specify:
- ○ U/K

h. For CO poisoning, was a CO detector present? ○ Yes ○ No ○ U/K

If yes, how many? _____

Functioning properly? ○ Yes ○ No ○ U/K

9. EXPOSURE

a. Circumstances, check all that apply:

- ☐ Abandonment
- ☐ Left in car
- ☐ Left in room
- ☐ Submerged in water
- ☐ Injured outdoors
- ☐ Lost outdoors
- ☐ Illegal border crossing
- ☐ Other, specify:
- ☐ U/K

b. Condition of exposure:

- ○ Hyperthermia
- ○ Hypothermia
- ○ U/K

_____ Ambient temp, degrees F

c. Number of hours exposed:

_____

☐ U/K

d. Was child wearing appropriate clothing?

- ○ Yes
- ○ No
- ○ U/K

10. MEDICAL CONDITION

a. How long did the child have the medical condition?

- ○ In utero
- ○ Since birth
- ○ Hours
- ○ Days
- ○ Weeks
- ○ Months
- ○ Years
- ○ U/K

b. Was death expected as a result of the medical condition?

- ○ N/A not previously diagnosed
- ○ Yes ☐ But at a later date
- ○ No
- ○ U/K

c. Was child receiving health care for the medical condition?

○ Yes ○ No ○ U/K

If yes, within 48 hours of the death?

○ Yes ○ No ○ U/K

d. Were the prescribed care plans appropriate for the medical condition?

- ○ N/A
- ○ Yes
- ○ No, specify:
- ○ U/K

e. Was child/family compliant with the prescribed care plans?

- ○ N/A
- ○ Yes
- ○ No
- ○ U/K

If no, what wasn't compliant? Check all that apply.

- ☐ Appointments
- ☐ Medications, specify:
- ☐ Medical equipment use, specify:
- ☐ Therapies, specify:
- ☐ Other, specify:
- ☐ U/K

f. Was child up to date with American Academy of Pediatrics immunization schedule?

- ○ N/A
- ○ Yes
- ○ No, specify:
- ○ U/K

g. Was the medical condition associated with an outbreak?

- ○ Yes, specify:
- ○ No
- ○ U/K

h. Was environmental tobacco exposure a contributing factor in death?

- ○ Yes
- ○ No
- ○ U/K

i. Were there access or compliance issues related to the death? ○ Yes ○ No ○ U/K If yes, check all that apply:

- ☐ Lack of money for care
- ☐ Limitations of health insurance coverage
- ☐ Multiple health insurance, not coordinated
- ☐ Lack of transportation
- ☐ No phone
- ☐ Cultural differences
- ☐ Religious objections to care
- ☐ Language barriers
- ☐ Referrals not made
- ☐ Specialist needed, not available
- ☐ Multiple providers, not coordinated
- ☐ Lack of child care
- ☐ Lack of family or social support
- ☐ Services not available
- ☐ Caregiver distrust of health care system
- ☐ Caregiver unskilled in providing care
- ☐ Caregiver unwilling to provide care
- ☐ Caregiver's partner would not allow care
- ☐ Other, specify:
- ☐ U/K

11. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

H. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG

a. Was this death a homicide, suicide, overdose, injury with the external cause as the only and obvious cause of death or a death which was expected within 6 months due to terminal illness? ○ Yes ○ No ○ U/K If yes, go to Section H2

b. Did the child have a history of any of the following acute conditions or symptoms within 72 hours prior to death? ☐ U/K for all

Symptom	Present w/in 72 hours of death			Present w/in 72 hours of death			
Cardiac	Yes	No	U/K		Yes	No	U/K
Chest pain	○	○	○	**Other Acute Symptoms**			
Dizziness/lightheadedness	○	○	○	Fever	○	○	○
Fainting	○	○	○	Heat exhaustion/heat stroke	○	○	○
Palpitations	○	○	○	Muscle aches/cramping	○	○	○
Neurologic				Slurred speech	○	○	○
Concussion	○	○	○	Vomiting	○	○	○
Confusion	○	○	○	Other, specify:	○		
Convulsions/seizure	○	○	○				
Headache	○	○	○				
Head injury	○	○	○				
Psychiatric symptoms	○	○	○				
Paralysis (acute)	○	○	○				
Respiratory							
Asthma	○	○	○				
Pneumonia	○	○	○				
Difficulty breathing	○	○	○				

c. At any time more than 72 hours preceding death did the child have a personal history of any of the following chronic conditions or symptoms? ☐ U/K for all

Symptom	Present more than 72 hours of death		
Cardiac	Yes	No	U/K
Chest pain	○	○	○
Dizziness/lightheadedness	○	○	○
Fainting	○	○	○
Palpitations	○	○	○
Neurologic			
Concussion	○	○	○
Confusion	○	○	○
Convulsions/seizure	○	○	○
Headache	○	○	○
Head injury	○	○	○
Respiratory			
Difficulty breathing	○	○	○
Other			
Slurred speech	○	○	○
Other, specify:	○		

d. Did the child have any prior serious injuries (e.g. near drowning, car accident, brain injury)?

○ Yes ○ No ○ U/K If yes, describe:

e. Had the child ever been diagnosed by a medical professional for the following? ☐ U/K for all

Condition	Diagnosed Yes	No	U/K
Blood disease			
Sickle cell disease	○	○	○
Sickle cell trait	○	○	○
Thrombophilia (clotting disorder)	○	○	○
Cardiac			
Abnormal electrocardiogram (EKG or ECG)	○	○	○
Aneurysm or aortic dilatation	○	○	○
Arrhythmia/arrhythmia syndrome	○	○	○
Cardiomyopathy	○	○	○
Commotio cordis	○	○	○
Congenital heart disease	○	○	○
Coronary artery abnormality	○	○	○
Coronary artery disease (atherosclerosis)	○	○	○
Endocarditis	○	○	○
Heart failure	○	○	○
Heart murmur	○	○	○
High cholesterol	○	○	○
Hypertension	○	○	○
Myocarditis (heart infection)	○	○	○
Pulmonary hypertension	○	○	○
Sudden cardiac arrest	○	○	○
Neurologic			
Anoxic brain Injury	○	○	○
Traumatic brain injury/ head injury/concussion	○	○	○
Brain tumor	○	○	○
Brain aneurysm	○	○	○
Brain hemorrhage	○	○	○
Developmental brain disorder	○	○	○

Condition	Diagnosed Yes	No	U/K
Neurologic (cont)			
Epilepsy/seizure disorder	○	○	○
Febrile seizure	○	○	○
Mesial temporal sclerosis	○	○	○
Neurodegenerative disease	○	○	○
Stroke/mini stroke/ TIA-Transient Ischemic Attack	○	○	○
Central nervous system infection (meningitis or encephalitis)	○	○	○
Respiratory			
Apnea	○	○	○
Asthma	○	○	○
Pulmonary embolism	○	○	○
Pulmonary hemorrhage	○	○	○
Respiratory arrest	○	○	○
Other			
Connective tissue disease	○	○	○
Diabetes	○	○	○
Endocrine disorder, other: thyroid, adrenal, pituitary	○	○	○
Hearing problems or deafness	○	○	○
Kidney disease	○	○	○
Mental illness/psychiatric disease	○	○	○
Metabolic disease	○	○	○
Muscle disorder or muscular dystrophy	○	○	○
Oncologic disease treated by chemotherapy or radiation	○	○	○
Prematurity	○	○	○
Congenital disorder/ genetic syndrome	○	○	○
Other, specify:	○		

If a more specific diagnosis is known, provide any additional information:

If any cardiac conditions above are selected, what cardiac treatments did the child have? Check all that apply: ☐ None

☐ Cardiac ablation
☐ Cardiac device placement (implanted cardioverter defibrillator (ICD) or pacemaker or Ventricular Assist Device (VAD))
☐ Heart surgery
☐ Interventional cardiac catheterization
☐ Heart transplant
☐ Other, specify:
☐ U/K

f. Did the child have any blood relatives (brothers, sisters, parents, aunts, uncles, cousins, grandparents or other more distant relatives) with the following diseases, conditions or symptoms? ☐ U/K for all

Y	N	U/K	Deaths
○	○	○	Sudden unexpected death before age 50
			Heart Disease
○	○	○	Heart condition/heart attack or stroke before age 50
○	○	○	Aortic aneurysm or aortic rupture
○	○	○	Arrhythmia (fast or irregular heart rhythm)
○	○	○	Cardiomyopathy
○	○	○	Congenital heart disease
			Neurologic Disease
○	○	○	Epilepsy or convulsions/seizure
○	○	○	Other neurologic disease

Y	N	U/K	Symptoms
○	○	○	Febrile seizures
○	○	○	Unexplained fainting
			Other Diagnoses
○	○	○	Congenital deafness
○	○	○	Connective tissue disease
○	○	○	Mitochondrial disease
○	○	○	Muscle disorder or muscular dystrophy
○	○	○	Thrombophilia (clotting disorder)
○	○	○	Other diseases that are genetic or run in families, specify:

If sudden unexpected death before age 50, describe (for example, SIDS, drowning, relative who died in single and/or unexplained motor vehicle accident (driver of car):

g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing?

○ Yes ○ No ○ U/K

If yes, describe what test and/or for what disease and results:

Was a gene mutation found?

○ Yes ○ No ○ U/K

h. In the 72 hours prior to death was the child taking any prescribed medication(s)?
○ Yes ○ No ○ U/K
If yes, describe:

i. Within 2 weeks prior to death had the child:

	N/A	Yes	No	U/K
Taken extra doses of prescribed medications	○	○	○	○
Missed doses of prescribed medications	○	○	○	○
Changed prescribed medications, describe:	○	○	○	○

j. Was the child compliant with their prescribed medications?
○ N/A ○ Yes ○ No ○ U/K
If not compliant, describe why and how often:

k. Was the child taking any of the following substance(s) within 24 hours of death?
Check all that apply: ☐ U/K for all

- ☐ Over the counter medicine
- ☐ Recent/short term prescriptions
- ☐ Energy drinks
- ☐ Caffeine
- ☐ Performance enhancers
- ☐ Diet assisting medications
- ☐ Supplements
- ☐ Tobacco
- ☐ Alcohol
- ☐ Illegal drugs
- ☐ Legalized marijuana
- ☐ Other, specify:

If yes to any items above, describe:

l. Did the child experience any of the following stimuli at time of incident or within 24 hours of the incident? ☐ U/K for all at time of incident ☐ U/K for all within 24 hours of incident

Stimuli	At incident Yes	No	U/K	Within 24 hrs of incident Yes	No	U/K
Physical activity	○	○	○	○	○	○
Sleep deprivation	○	○	○	○	○	○
Driving	○	○	○	○	○	○
Visual stimuli	○	○	○	○	○	○
Video game stimuli	○	○	○	○	○	○
Emotional stimuli	○	○	○	○	○	○
Auditory stimuli/startle	○	○	○	○	○	○
Physical trauma	○	○	○	○	○	○
Other, specify:	○			○		

If yes to physical activity, describe type of activity:
At incident Within 24 hours of incident

Other specify:
At incident Within 24 hours of incident

m. Did the child ever have any of the following **uncharacteristic** symptoms during or within 24 hours after physical activity? Check all that apply:

- ☐ Chest pain
- ☐ Confusion
- ☐ Convulsions/seizure
- ☐ Dizziness/lightheadedness
- ☐ Fainting
- ☐ Headache
- ☐ Palpitations
- ☐ Shortness of breath/difficulty breathing
- ☐ Other, specify:
- ☐ U/K

If yes to any item, describe type of physical activity and extent of symptoms:

n. For child age 12 or older, did the child receive a pre-participation exam for a sport?
○ N/A ○ Yes ○ No ○ U/K
If yes:
Was it done within a year prior to death? ○ Yes ○ No ○ U/K
Did the exam lead to restrictions for sports or otherwise? ○ Yes ○ No ○ U/K
If yes, specify restrictions:

Questions o through u: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)

o. How old was the child when diagnosed with epilepsy/seizure disorder?
Age 0 (infant) through 20 years: _____
☐ U/K

p. What were the underlying cause(s) of the child's seizures? Check all that apply:

- ☐ Brain injury/trauma, specify:
- ☐ Brain tumor
- ☐ Cerebrovascular
- ☐ Central nervous system infection
- ☐ Degenerative process
- ☐ Developmental brain disorder
- ☐ Inborn error of metabolism
- ☐ Genetic/chromosomal
- ☐ Mesial temporal sclerosis
- ☐ Idiopathic or cryptogenic
- ☐ Other acute illness or injury other than epilepsy
- ☐ Other, specify:
- ☐ U/K

q. What type(s) of seizures did the child have? Check all that apply:

- ☐ Non-convulsive
- ☐ Convulsive (grand mal seizure or generalized tonic-clonic seizure)
- ☐ Occur when exposure to strobe lights, video game, or flickering light (reflex seizure)
- ☐ U/K

r. Describe the child's epilepsy/seizures. Check all that apply:

- ☐ Last less than 30 minutes
- ☐ Last more than 30 minutes (status epilepticus)
- ☐ Occur in the presence of fever (febrile seizure)
- ☐ Occur in the absence of fever
- ☐ Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)

s. How many seizures did the child have in the year preceding death?
○ 0/never ○ 1 ○ 2 ○ 3 ○ more than 3 ○ U/K

t. Did treatment for seizures include anti-epileptic drugs?
○ Yes ○ No ○ U/K
If yes, how many different types of anti-epilepsy drugs (AED) did the child take?
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ more than 6 ○ U/K

u. Was night surveillance used?
○ Yes ○ No ○ U/K

2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? ○ Yes, go to H2a ○ No, go to H2s ○ U/K, go to H2s

a. Incident sleep place: !
○ Crib
If crib, type:
○ Not portable
○ Portable, e.g. pack-n-play
○ Unknown crib type
○ Bassinette
○ Adult bed
○ Waterbed
○ Futon
○ Playpen/other play structure but not portable crib
○ Couch
○ Chair
○ Floor
○ Car seat
○ Stroller
○ Other, specify:
○ U/K

If adult bed, what type?
○ Twin ○ Full ○ Queen ○ King ○ Other, specify: ○ U/K

If futon,
○ Bed position ○ Couch position ○ U/K

b. Child put to sleep:
- On back
- On stomach
- On side
- U/K

c. Child found:
- On back
- On stomach
- On side
- U/K

e. Usual sleep position:
- On back
- On stomach
- On side
- U/K

f. Was there a crib, bassinette or port-a-crib in home for child?
- Yes
- No
- U/K

d. Usual sleep place:
- Crib
  - If crib, type:
    - Not portable
    - Portable, e.g. pack-n-play
    - Unknown crib type
- Bassinette
- Adult bed
- Waterbed
- Futon
- Playpen/other play structure but not portable crib
- Couch
- Chair
- Floor
- Car seat
- Stroller
- Other, specify:
- U/K

If adult bed, what type?
- Twin
- Full
- Queen
- King
- Other, specify:
- U/K

If futon,
- Bed position
- Couch position
- U/K

g. Child in a new or different environment than usual?
- Yes
- No
- U/K

If yes, specify:

h. Child last placed to sleep with a pacifier?
- Yes
- No
- U/K

i. Child wrapped or swaddled in blanket?
- Yes
- No
- U/K

If yes, describe:

j. Child overheated?
- Yes
- No
- U/K

If yes, outside temp ____ degrees F

Check all that apply:
- Room too hot, temp ____ degrees F
- Too much bedding
- Too much clothing

k. Child exposed to second hand smoke?
- Yes
- No
- U/K

If yes, how often:
- Frequently
- Occasionally
- U/K

l. Child face when found:
- Down
- Up
- To left or right side
- U/K

m. Child neck when found:
- Hyperextended (head back)
- Hypoextended (chin to chest)
- Neutral
- U/K

n. Child's airway was:
- Unobstructed by person or object
- Fully obstructed by person or object
- Partially obstructed by person or object
- U/K

If fully or partially obstructed, what was obstructed?
- Nose
- Mouth
- Chest compressed
- U/K

o. Objects in child's sleep environment in relation to airway obstruction:

Objects:	Present? Yes	No	U/K	If **present**, describe position of object: On top of child	Under child	Next to child	Tangled around child	U/K	If **present**, did object obstruct airway? Yes	No	UK
Adult(s)											
Other child(ren)											
Animal(s)											
Mattress											
Comforter, quilt, or other											
Thin blanket/flat sheet											
Pillow(s)											
Cushion											
Boppy or U shaped pillow											
Sleep positioner (wedge)											
Bumper pads											
Clothing											
Crib railing/side											
Wall											
Toy(s)											
Other(s), specify:											
_____											
_____											

p. Caregiver/supervisor fell asleep while feeding child?
- Yes
- No
- U/K

If yes, type of feeding:
- Bottle
- Breast
- U/K

q. Child sleeping in the same room as caregiver/supervisor at time of death?
- Yes
- No
- U/K

r. Child sleeping on same surface with person(s) or animal(s)?
- Yes
- No
- U/K

If yes, check all that apply:
- With adult(s):
  - #_____ #U/K
  - Adult obese: Yes / No / U/K
- With other children:
  - #_____ #U/K
  - Children's ages: _____
- With animal(s):
  - #_____ #U/K
  - Type(s) of animal: _____
- U/K

s. Is there a scene re-creation photo available for upload? Yes / No

If yes, upload here. Only one photo allowed.

Select photo that most describes child placement and relevant objects. Size must be less than 6 mb and in .jpg or .gif format.

3. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT?
- Yes
- No, go to H4
- U/K, go to H4

a. Describe product and circumstances:

b. Was product used properly?
- Yes
- No
- U/K

c. Is a recall in place?
- Yes
- No
- U/K

d. Did product have safety label?
- Yes
- No
- U/K

e. Was Consumer Product Safety Commission (CPSC) notified?
- Yes
- U/K
- No, go to www.saferproducts.gov to report

4. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? ○ Yes ○ No ○ U/K

a. Type of crime, check all that apply:

! ☐ Robbery/burglary ☐ Other assault ☐ Arson ☐ Illegal border crossing ☐ U/K
☐ Interpersonal violence ☐ Gang conflict ☐ Prostitution ☐ Auto theft
☐ Sexual assault ☐ Drug trade ☐ Witness intimidation ☐ Other, specify:

I. ACTS OF OMISSION OR COMMISSION INCLUDING POOR SUPERVISION, CHILD ABUSE & NEGLECT, ASSAULTS, AND SUICIDE

TYPE OF ACT

1. Did any act(s) of omission or commission cause and/or contribute to the death?
○ Yes
○ No, go to Section J
○ Probable
○ U/K, go to Section J

If yes/probable, were the act(s) either or both? Check all that apply:
☐ The direct cause of death
☐ The contributing cause of death

2. What act(s) caused or contributed to the death? Check only one per column and describe in narrative.

Caused	Contributed	
○	○	Poor/absent supervision, go to 10
○	○	Child abuse, go to 3
○	○	Child neglect, go to 8
○	○	Other negligence, go to 9
○	○	Assault, not child abuse, go to 10
○	○	Religious/cultural practices, go to 10
○	○	Suicide, go to 27
○	○	Medical misadventure, specify and go to 11
○	○	Other, specify and go to 10
○	○	U/K, go to 10

3. Child abuse, type. Check all that apply and describe in narrative.
☐ Physical, go to 4
☐ Emotional, specify and go to 10
☐ Sexual, specify and go to 10
☐ U/K, go to 10

4. Type of physical abuse, check all that apply:
☐ Abusive head trauma, go to 5
☐ Chronic Battered Child Syndrome, go to 7
☐ Beating/kicking, go to 7
☐ Scalding or burning, go to 7
☐ Munchausen Syndrome by Proxy, go to 7
☐ Other, specify and go to 7
☐ U/K, go to 7

5. For abusive head trauma, were there retinal hemorrhages?
○ Yes ○ No ○ U/K

6. For abusive head trauma, was the child shaken?
○ Yes ○ No ○ U/K
If yes, was there impact?
○ Yes ○ No ○ U/K

7. Events(s) triggering physical abuse, check all that apply:
☐ None
☐ Crying
☐ Toilet training
☐ Disobedience
☐ Feeding problems
☐ Domestic argument
☐ Other, specify:
☐ U/K

8. Child neglect, check all that apply:
☐ Failure to protect from hazards, specify:
☐ Failure to provide necessities
☐ Food
☐ Shelter
☐ Other, specify:
☐ Failure to seek/follow treatment, specify:
☐ Emotional neglect, specify:
☐ Abandonment, specify:
☐ U/K

9. Other negligence:
○ Vehicular
○ Other, specify:
○ U/K

10. Was act(s) of omission/commission:

Caused	Contributed	
○	○	Chronic with child
○	○	Pattern in family or with perpetrator
○	○	Isolated incident
○	○	U/K

PERSON(S) RESPONSIBLE

11. Is person the caregiver or supervisor in previous section? !

Caused	Contributed	
○	○	Yes, caregiver one, go to 24
○	○	Yes, caregiver two, go to 24
○	○	Yes, supervisor, go to 25
○	○	No

12. Primary person responsible for action(s) that caused and/or contributed to death: ! Select no more than one person for caused and one person for contributed.

Caused	Contributed		Caused	Contributed		Caused	Contributed	
○	○	Self, go to 24	○	○	Grandparent	○	○	Medical provider
○	○	Biological parent	○	○	Sibling	○	○	Institutional staff
○	○	Adoptive parent	○	○	Other relative	○	○	Babysitter
○	○	Stepparent	○	○	Friend	○	○	Licensed child care worker
○	○	Foster parent	○	○	Acquaintance			
○	○	Mother's partner	○	○	Child's boyfriend or girlfriend	○	○	Other, specify:
○	○	Father's partner	○	○	Stranger	○	○	U/K

13. Person's age in years: !

Caused	Contributed	
____	____	# Years
☐	☐	U/K

14. Person's sex: !

Caused	Contributed	
○	○	Male
○	○	Female
○	○	U/K

15. Does person speak English? !

Caused	Contributed	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

16. Person on active military duty? !

Caused	Contributed	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify branch:

17. Person have history of substance abuse?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

- Alcohol
- Cocaine
- Marijuana
- Methamphetamine
- Opiates
- Prescription drugs
- Over-the-counter
- Other, specify:
- U/K

18. Person have history of child maltreatment as victim?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

- Physical
- Neglect
- Sexual
- Emotional/ psychological
- U/K
- _____ _____ # CPS referrals
- _____ _____ # Substantiations
- Ever in foster care or adopted

19. Person have history of child maltreatment as a perpetrator?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

- Physical
- Neglect
- Sexual
- Emotional/psychological
- U/K
- _____ _____ # CPS referrals
- _____ _____ # Substantiations
- CPS prevention services
- Family preservation services
- Children ever removed

20. Person have disability or chronic illness?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

- Physical, specify:
- Mental, specify:
- Sensory, specify:
- U/K

If mental illness, was person receiving MH services?

Yes / No / U/K

21. Person have prior child deaths?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

- Child abuse #_____
- Child neglect #_____
- Accident #_____
- Suicide #_____
- SIDS #_____
- Other #_____

Other, specify:

- U/K

22. Person have history of intimate partner violence?

Caused / Contributed:

- Yes, as victim
- Yes, as perpetrator
- No
- U/K

23. Person have delinquent/criminal history?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

- Assaults
- Robbery
- Drugs
- Other, specify:
- U/K

24. At time of incident was person impaired?

Caused: Yes / No / U/K

Contributed: Yes / No / U/K

If yes, check all that apply:

Caused / Contributed:

- Drug impaired
- Alcohol impaired
- Asleep
- Distracted
- Absent
- Impaired by illness, specify:
- Impaired by disability, specify:
- Other, specify:

25. Does person have, check all that apply:

Caused / Contributed:

- Prior history of similar acts
- Prior arrests
- Prior convictions

26. Legal outcomes in this death, check all that apply:

Caused / Contributed:

- No charges filed
- Charges pending
- Charges filed, specify:
- Charges dismissed
- Confession
- Plead, specify:
- Not guilty verdict
- Guilty verdict, specify:
- Tort charges, specify:
- U/K

FOR SUICIDE

27. For suicide, select yes, no or u/k for each question. Describe answers in narrative.

Yes	No	U/K		Yes	No	U/K	
○	○	○	A note was left	○	○	○	Child had a history of self mutilation
○	○	○	Child talked about suicide	○	○	○	There is a family history of suicide
○	○	○	Prior suicide threats were made	○	○	○	Suicide was part of a murder-suicide
○	○	○	Prior attempts were made	○	○	○	Suicide was part of a suicide pact
○	○	○	Suicide was completely unexpected	○	○	○	Suicide was part of a suicide cluster
○	○	○	Child had a history of running away				

28. For suicide, was there a history of acute or cumulative personal crises that may have contributed to the child's despondency? Check all that apply:

- None known
- Family discord
- Parents' divorce/separation
- Argument with parents/caregivers
- Argument with boyfriend/girlfriend
- Breakup with boyfriend/girlfriend
- Argument with other friends
- Rumor mongering
- Suicide by friend or relative
- Other death of friend or relative
- Bullying as victim
- Bullying as perpetrator
- School failure
- Move/new school
- Other serious school problems
- Pregnancy
- Physical abuse/assault
- Rape/sexual abuse
- Problems with the law
- Drugs/alcohol
- Sexual orientation
- Religious/cultural issues
- Job problems
- Money problems
- Gambling problems
- Involvement in cult activities
- Involvement in computer or video games
- Involvement with the Internet, specify:
- Other, specify:
- U/K

J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services: Select one option per row:	Provided after death	Offered but refused	Offered but U/K if used	Should be offered	Needed but not available	U/K	CDR review led to referral
Bereavement counseling	○	○	○	○	○	○	☐
Debriefing for professionals	○	○	○	○	○	○	☐
Economic support	○	○	○	○	○	○	☐
Funeral arrangements	○	○	○	○	○	○	☐
Emergency shelter	○	○	○	○	○	○	☐
Mental health services	○	○	○	○	○	○	☐
Foster care	○	○	○	○	○	○	☐
Health services	○	○	○	○	○	○	☐
Legal services	○	○	○	○	○	○	☐
Genetic counseling	○	○	○	○	○	○	☐
Other, specify:	○	○	○	○	○	○	☐

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

○ Mark this case to edit/add prevention actions at a later date

1. Could the death have been prevented? ○ Yes, probably ○ No, probably not ○ Team could not determine

2. What specific recommendations and/or initiatives resulted from the review? Check all that apply: ○ No recommendations made, go to Section L

		Current Action Stage			Type of Action		Level of Action		
		Recommendation	Planning	Implementation	Short term	Long term	Local	State	National
Education	Media campaign	○	○	○	☐	☐	☐	☐	☐
	School program	○	○	○	☐	☐	☐	☐	☐
	Community safety project	○	○	○	☐	☐	☐	☐	☐
	Provider education	○	○	○	☐	☐	☐	☐	☐
	Parent education	○	○	○	☐	☐	☐	☐	☐
	Public forum	○	○	○	☐	☐	☐	☐	☐
	Other education	○	○	○	☐	☐	☐	☐	☐
Agency	New policy(ies)	○	○	○	☐	☐	☐	☐	☐
	Revised policy(ies)	○	○	○	☐	☐	☐	☐	☐
	New program	○	○	○	☐	☐	☐	☐	☐
	New services	○	○	○	☐	☐	☐	☐	☐
	Expanded services	○	○	○	☐	☐	☐	☐	☐
Law	New law/ordinance	○	○	○	☐	☐	☐	☐	☐
	Amended law/ordinance	○	○	○	☐	☐	☐	☐	☐
	Enforcement of law/ordinance	○	○	○	☐	☐	☐	☐	☐
Environment	Modify a consumer product	○	○	○	☐	☐	☐	☐	☐
	Recall a consumer product	○	○	○	☐	☐	☐	☐	☐
	Modify a public space	○	○	○	☐	☐	☐	☐	☐
	Modify a private space(s)	○	○	○	☐	☐	☐	☐	☐
	Other, specify:	○	○	○	☐	☐	☐	☐	☐

Briefly describe the initiatives:

3. Who took responsibility for championing the prevention initiatives? Check all that apply:

☐ N/A, no strategies	☐ Mental health	☐ Law enforcement	☐ Advocacy organization	☐ Other, specify:
☐ No one	☐ Schools	☐ Medical examiner	☐ Local community group	
☐ Health department	☐ Hospital	☐ Coroner	☐ New coalition/task force	
☐ Social services	☐ Other health care providers	☐ Elected official	☐ Youth group	☐ U/K

L. THE REVIEW MEETING PROCESS

1. Date of first CDR meeting:

2. Number of CDR meetings for this case: _____

3. Is CDR complete? ○ N/A ○ Yes ○ No

4. Agencies at CDR meeting, check all that apply:

☐ Medical examiner/coroner	☐ CPS	☐ Other health care	☐ Mental health	☐ Military
☐ Law enforcement	☐ Other social services	☐ Fire	☐ Substance abuse	☐ Others, list:
☐ Prosecutor/district attorney	☐ Physician	☐ EMS	☐ Court	
☐ Public health	☐ Hospital	☐ Education	☐ Child advocate	

5. Were the following data sources available at the CDR meeting?

Check all that apply:

- ☐ CDC's SUIDI Reporting Form
- ☐ Jurisdictional equivalent of the CDC SUIDI Reporting Form
- ☐ Birth certificate - full form
- ☐ Death certificate
- ☐ Child's medical records or clinical history, including vaccinations
- ☐ Biological mother's obstetric and prenatal information
- ☐ Newborn screening results
- ☐ Law enforcement records
- ☐ Social service records
- ☐ Child protection agency records
- ☐ EMS run sheet
- ☐ Hospital records
- ☐ Autopsy/pathology reports
- ☐ Mental health records
- ☐ School records
- ☐ Substance abuse treatment records

6. Factors that prevented an effective CDR meeting, check all that apply:

- ☐ Confidentiality issues among members prevented full exchange of information
- ☐ HIPAA regulations prevented access to or exchange of information
- ☐ Inadequate investigation precluded having enough information for review
- ☐ Team members did not bring adequate information to the meeting
- ☐ Necessary team members were absent
- ☐ Meeting was held too soon after death
- ☐ Meeting was held too long after death
- ☐ Records or information were needed from another locality in-state
- ☐ Records or information were needed from another state
- ☐ Team disagreement on circumstances
- ☐ Other factors, specify:

7. CDR meeting outcomes, check all that apply:

- ☐ Review led to additional investigation
- ☐ Team disagreed with official manner of death. What did team believe manner should be?
- ☐ Team disagreed with official cause of death. What did team believe cause should be?
- ☐ Because of the review, the official cause or manner of death was changed
- ☐ Review led to the delivery of services
- ☐ Review led to changes in agency policies or practices
- ☐ Review led to prevention initiatives being implemented
  - ☐ Local ☐ State ☐ National

8. Describe the factor(s) that directly contributed to this death:

9. Which of the factors that directly contributed to this death are modifiable?

10. List any recommendations to prevent deaths from similar causes or circumstances in the future:

11. What additional information would the team like to know about the death scene investigation?

12. What additional information would the team like to know about the autopsy?

M. SUID AND SDY CASE REGISTRY

1. Is this an SDY or SUID case? ○ Yes ○ No — If no, go to Section N

2. Did this case go to Advance Review for the SDY Case Registry?
○ N/A ○ Yes ○ No
If yes, date of first Advance Review meeting:

3. Notes from Advance Review meeting:

4. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary? ○ Yes ○ No ○ U/K

5. Was a specimen sent to the SDY Case Registry bio-repository?
○ Yes ○ No ○ N/A ○ U/K

6. Did the family consent to the SDY Case Registry?
○ Yes ○ No ○ N/A ○ U/K

7. Categorization for SDY Case Registry (choose only one):

- ○ Excluded from SDY Case Registry
- ○ No autopsy or death scene investigation
- ○ Incomplete case information
- ○ Explained cardiac
- ○ Explained neurological
- ○ Explained infant suffocation (under age 1)
- ○ Explained other
- ○ Unexplained, possible cardiac
- ○ Unexplained, possible cardiac and SUDEP
- ○ Unexplained, SUDEP
- ○ Unexplained infant death (under age 1)
- ○ Unexplained child death (age 1 and over)

8. Categorization for SUID Case Registry (choose only one):

- ○ Excluded (other explained causes, not suffocation)
- ○ Unexplained: No autopsy or death scene investigation
- ○ Unexplained: Incomplete case information
- ○ Unexplained: No unsafe sleep factors
- ○ Unexplained: Unsafe sleep factors
- ○ Unexplained: Possible suffocation with unsafe sleep factors
- ○ Explained: Suffocation with unsafe sleep factors

If possible suffocation or explained suffocation, select the primary mechanism(s) leading to the death, check all that apply:

- ☐ Soft bedding
- ☐ Wedging
- ☐ Overlay
- ☐ Other, specify:

N. NARRATIVE

Use this space to provide more detail on the circumstances of the death and to describe any other relevant information.
DO NOT INCLUDE IDENTIFIERS IN THE NARRATIVE such as names, addresses, and specific service providers. Consider the following questions: What was the child doing? Where did it happen? How did it happen? What went wrong? What was the quality of supervision? What was the injury cause of death?

!

Standard template for narratives should be used as follows:

Interpretive Summary

What does the committee think happened? - brief case summary (tell us the story)

Lessons learned

Did the family have prevention services in the past?

Was communication between intra-agencies sufficient?

Any training issues identified?

O. FORM COMPLETED BY:

PERSON:

TITLE:

AGENCY:

PHONE:

!

EMAIL:

DATE COMPLETED:

DATA ENTRY COMPLETED FOR THIS CASE? ☐

For State Program Use Only:
DATA QUALITY ASSURANCE COMPLETED BY STATE ☐

The National Center for the REVIEW & PREVENTION OF CHILD DEATHS

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Data Entry: https://cdrdata.org
www.childdeathreview.org
For help, email: info@childdeathreview.org
1-800-656-2434

APPENDIX F:

Prevention Activities Informed by CADR Data

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
Circuit 3	Madison, Taylor, Columbia, Suwannee, Dixie, Lafayette, Hamilton	Community Collaboration	Circuit 3 was newly formed this year; a completely new team was developed to adapt to judicial realignment. The newly formed committee is made up of 7 rural counties with similar demographics. This allowed for focused discussion regarding concerns specific to rural counties. Topics that surfaced during case reviews prompted each agency to share what they are doing in response to the topic. For example, two cases reviewed included co-sleeping deaths; each agency discussed their current practices/policies to inform parents about the risks of co-sleeping.	n/a
Circuit 6	Pinellas, Pasco	Community Collaboration Water Safety Safe Sleep	The Local CADR Local CADR committee reports trends and prevention strategies to our Preventable Death Committee. We work together as a community to ensure we are sharing information on water safety, swimming lessons, speaking opportunities, strategies etc. Please see the attached one-page outline of our committee.	Warning Signs Campaign Update *(Word document)*
Circuit 7	St. Johns	Community Collaboration Substance Abuse Health Equity	As a result of the Circuit 7 CADR reviews, St Johns County has, or is in the process of, implementing the following activities: • Due to a heightened awareness of multiple community agency involvement yet limited communication and/or coordination between agencies, re: shared high risk families, we are in the initial planning phase of developing a multiagency 'rapid response' team approach for infants and children in identified heightened or imminent risk. • Due to heightened awareness of maternal substance abuse as an increasing factor in infant and child deaths, a Neonatal Abstinence Workgroup has been established within the St Johns County Infant Mortality Task Force. • A Health Equity framework, using social determinants of health, has been adopted for which assessments, services, programs etc. are developed and/or refined.	n/a
Circuit 9	Orange, Osceola	Safe Sleep Water Safety Community Collaboration	The data from the local team is used to inform practice and focus resources on priority issues. For instance, the local CADR action committee pulled and reviewed causes of death and manners and used it to focus on the top two initiatives which were safe sleep and water safety. The committee also reviewed common factors to the deaths, such as prior DCF reports, ages, etc. and the zip codes experiencing the highest number of deaths. This provides the framework to focus interventions to those populations at highest risk. The local circuit data is presented to the Children's Cabinets in both Orange and Osceola counties in the form of a scorecard related to the 5 Year Child Abuse Prevention circuit plan and Children's Cabinet	n/a

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
			members are asked to focus in on supporting the focus areas for prevention. The data also guides local initiatives, such as the Osceola Safe Families Task Force, Healthy Babies Initiatives and other local groups and safe sleep practice education is being infused into many family support programs.	
Circuit 12	Manatee	Safe Sleep	The Florida Department of Health in Manatee County, along with community partners, has utilized the data from the CADR to create a Safe Sleep campaign for parents. The campaign partners are The Healthy Start Coalition of Manatee County, the Manatee Sheriff's Office, and Manatee Education Television (METV). The Safe Sleep campaign was created in 2005 as a result of a review of infant and child deaths in Manatee County. The emphasis on parent education about safe sleep practices along with the provision of Moses Baskets to families in need is one factor that may have contributed to the decrease in the Manatee County infant mortality rate from 2007 to 2014. Parent education and support are provided in English and Spanish utilizing pamphlets and an educational DVD created in partnership with METV. Parent education focuses on creating a safe sleep environment, avoidance of co-sleeping, and proper clothing and position for the infant. The campaign also provides Moses Baskets to parents who do not have a safe sleep environment for their newborn infant. The baskets are created in partnership with the Healthy Start Coalition of Manatee County and the Manatee Sheriff's Office. DOH-Manatee and community partners continue to innovate to provide safe sleep education. Displays of a safe sleep environment, including a Moses basket along with parent education materials, are currently planned for two DOH-Manatee clinic sites.	CADR Data Review and Impact: Manatee County *(Word document)*
Circuit 12	Sarasota	Safe Sleep Water Safety	One of the efforts in Sarasota that was a direct result of the CADR team meeting in 2014 is the Safe Sleep Sarasota initiative. I'm including a link to the Healthy Start website that has a summary and goals of this initiative listed out, along with the power point that is used when training community partners. We also developed a safe sleep pledge that the parents are signing (following a brief training) at the discharge brunch when parents are getting ready to go home with their newborns. I've attached a copy of one I have, but it likely has been updated since. The Safe Sleep summary includes our community efforts for the last fiscal year. Since our last meeting which included 2 child drownings, we are now including training curriculum related to mandated reporting. Representative Gonzalez, one of	Link to Safe Sleep Sarasota Initiative *(Web link)* Safe Sleep Training (*PowerPoint)* Safe Sleep Pledge *(Word document)*

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
			our newest members, attended the last CADR meeting and was VERY interested in championing the bill to direct funding for all of the YMCA's in the state to be able to provide free swim lessons in an effort to help prevent child drownings. This bill died last year and he felt it was important to bring it back again.	Safe Sleep Summary *(Word document)*
Circuit 14	Gulf, Franklin, Washington, Bay, Calhoun, Holmes, Jackson	Child Passenger Safety Parenting Support Community Collaboration	Child Passenger Safety Awareness Campaigns: • The Gulf County Tobacco Prevention Partnership and Healthy Start Program hosted an event in order to promote the safety of children in vehicles. Held at North Florida Child Development in Port St. Joe, 15 families signed up for Car Seat Installment Checks, provided by a Healthy Start Certified Specialist. Additionally, Gulf County Tobacco Prevention Program Coordinator shared educational information about the dangers of secondhand smoke in vehicles with parents and caregivers. • DOH- Franklin Healthy Start Program hosted a Car Seat Safety Inspection event in October 2016 to promote the safety of children in vehicles. These events were held in partnership with community agencies such as North Florida Child Development, Franklin County Sheriff's Office and Weems' Emergency Medical Services. Circle of Parents: • As part of the new Healthy Moms and Babies program initiative, there were five Circle of Parents ® Meetings were held in Gulf County. Circle of Parents® provides a friendly, supportive environment led by parents and other caregivers. It's a place where anyone in a parenting role can openly discuss the successes and challenges of raising children. There were 45 parent participants. Collaboration with local councils and committees *(Mental Health / Substance Abuse)*: • The Gulf County Community Health Improvement Partners formed a Mental Health/Substance Abuse subcommittee based on the need to link individuals and families to these services. Partners include mental health and substance abuse providers, faith-based organizations, police, schools, Healthy Start, and the Bureau of Alcohol, Tobacco and Firearms. Recently, the first Mental	n/a

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
			Health/Substance Abuse resource guide for Gulf and Franklin residents was created and distributed throughout communities.	
Circuit 15	Palm Beach	Water Safety Safe Sleep Mental Health & Substance Abuse Fire Safety Community Collaboration	• The Drowning Prevention Coalition (DPC) provided water safety education programming to 562 summer camp children during the month of July and up until the beginning of school. Since the start of the 2016/2017 school year, the DPC has provided water safety presentations to all children at three elementary schools (1,806 students). In addition, another 1,197 students benefited from land-based programming via pre-school, health class, physical education, and fine arts. Ultimately, 40,631 people were educated about the importance of water safety during a total of 70 different activities and presentations. • Partnerships promoting community education are numerous. They range from providing literature at resource fairs; speaking at community forums; or providing portable cribs to families. These efforts cover a variety of topics that include drowning prevention; safe sleep; gang avoidance education; drug and alcohol misuse by underage youth; leaving children in hot cars; proper nutrition and exercise; proper parenting techniques; and anti-violence campaigns. • Hanley Center Foundation partners with Friends of Foster Children to provide Youth Mental Health First Aid twice a year. This enables foster parents 8 hours of mental health/suicide prevention training. In the past 2 years we have served nearly 100 parents with this program. • As a result of Palm Beach County Fire Rescue's involvement with CADR we continue to promote Child Safety in schools, Homeowners Associations, Scout, Libraries, etc. covering the 8 major causes of death and injury to children. We at PBCFR partner with the Palm Beach County Drowning Prevention Coalition, Safe Kids Palm Beach County, Children's Home Society, Palm Beach County Health Department and the list goes on so that we can make Palm Beach County a safer place for our children. PCBFR also has a 30-minute television program on Channel 20 where we have done programming on issues currently happening in the County. The January segment will cover Safe Sleeping which we know is an issue for CADR; CADR team members that are SMEs on this topic will be involved in the segment. • Southeast Florida Behavioral Health Network is highly involved with integrating behavioral health services and child welfare. For the past 3 years we have been collaborating with Child Net and Devereux CBC's and began subcontracting with several of our providers to operate a hotline/call center for	Drowning Prevention Coalition of WPB *(Word document)* Prevention Partnerships *(Word document)* PBCFR Email *(full text)* SE Florida Behavioral Network Email *(full text)*

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
			Child Protective Investigators to call and get parents needing substance abuse assessments and services immediate appointments. We also contract with a provider for a FIT Team, (Family Intensive Treatment) Team. The team provides behavioral health services to families involved in child welfare system to prevent further abuse and/or neglect and get families the help they need and back on track.	
Circuit 19	Indian River	Safe Sleep	In Indian River we are looking at starting a baby box initiative with healthy start.	
Circuit 20	Collier, Lee, Charlotte, Hendry, Glades	Community Collaboration Process Improvements	Collier, Lee, Charlotte and Hendry/Glades have been reorganized into what is now Circuit 20. The last part of 2015 and the first part of 2016 have been spent mostly in reorganization work, finishing up 2015 cases and setting the new system into place. A recent addition of a dedicated clerical support is hopefully going to expedite completed case submissions and allow the chair and members of the group to focus on more of the evaluative purpose of the Circuit Group rather than spending time on process issues.	
NE Region (DCF)		Community Collaboration	The Northeast Region uses findings from the statewide CADR and our local CADR Teams. We are very involved in our local teams and have used information for many years to guide our prevention work as well as our quality investigative/case management/and provider work. Examples follow: 1. Creation of our Circuit Child Fatality Prevention Consortiums 2. Safety Initiative NER: 3 years ago we initiated the Safety Campaign in NER to equip our Child Protection and Case Management staff with safety items so they can, on site, provide them to families accompanied by a mini training on safety. 3. We use findings and recommendation to drive quality work in areas such as how the Investigators partner with CPT; with medical providers to get information and participate in cross training and staffings; how we utilize Multi-Disciplinary Teams and when; prevention work while in homes; etc. 4. CADR findings drive community discussions; media interactions; and action teams. We share data sheets showing exactly by County what is happening and at what frequency so they are aware. This has shown some impact in areas such as in our Substance Abuse provider agencies where they have incorporated home safety questions. 5. Data: We use monthly data on all child fatalities to drive discussions.	CADR Findings NE region DCF *(Word document, full text)*

APPENDIX G:

Child Abuse Death Review Data

CHILD DEATH INCIDENT INFORMATION

Location of Child Deaths

Tables G-1 and G-2 provide information related to the number of child fatalities that occurred in each county in Florida. Please note that the county refers to the county where the incident took place, not necessarily the county where the death occurred (although they may be the same county). By way of explanation, there are occasions where the incident causing a child's death may happen in one county; however, the child's death (for example, because he/she was transported to a medical facility in another county) may be documented in another county. From a prevention standpoint, for this report, any county reference refers to the county where the incident contributing to the death (i.e., "death county") took place. Table G-1 highlights every child death across individual counties stratified by maltreatment verification status and primary cause of death (i.e., drowning, asphyxia, weapon, and other). Table G-2 aggregates information denoted in Table G-1 for all primary causes of death for each county and includes those cases for which the primary cause of death was undetermined or unknown (most likely associated with non-verified child maltreatment deaths). No information in a table cell in either Table G-1 or Table G-2 indicates a zero count for that county category.

When information from Table G-1 is examined, there are four counties that account for approximately 40% of the verified child maltreatment deaths (across all categories) in Florida thus far reviewed. These include Broward (n=9), Duval (n=9), Brevard (n=7), and Pinellas (n=7, includes 1 case whose cause of death was "undetermined"). Verified child maltreatment deaths happened in 23 additional counties throughout Florida for a total of 27 or 40.3% of Florida's 67 counties. When primary cause of death among verified maltreatment cases are examined, 45.2% (14 of 31) of all drowning deaths took place in only three counties. These include Broward (n=6), Duval (n=4), and Lee (n=4). The remaining verified maltreatment drowning deaths were located in thirteen additional counties. Verified maltreatment deaths involving asphyxia were located in ten counties where the most were represented in Brevard (n=3) and Pinellas (n=3). The remaining eight asphyxia deaths are found across eight additional counties (one in each county). The 14 verified maltreatment deaths by weapons are found across nine different counties in Florida with the greatest number occurring in Duval (n=4).

Table G-1: Distribution of Verified and Non-verified Child Maltreament Deaths Across Florida Counties by Primary Cause of Death

County	Verified for Maltreatment					County	Non-Verified for Maltreatment				
	Drowning	Asphyxia	Weapon	Other	Total		Drowning	Asphyxia	Weapon	Other	Total
Alachua					0	Alachua		1		1	2
Baker					0	Baker					0
Bay					0	Bay					0
Bradford					0	Bradford					0
Brevard	1	3	1	2	7	Brevard		2		3	5
Broward	6	1		2	9	Broward	1	1		9	11
Calhoun					0	Calhoun					0
Charlotte					0	Charlotte	2				2
Citrus					0	Citrus	3	1			4
Clay					0	Clay	1	2		2	5
Collier					0	Collier	1				1
Columbia			1		1	Columbia				3	3
DeSoto					0	DeSoto					0
Dixie					0	Dixie					0
Duval	4		4	1	9	Duval		12	2	11	25
Escambia					0	Escambia	1	1		2	4
Flagler					0	Flagler					0
Franklin					0	Franklin					0
Gadsden					0	Gadsden					0
Gilchrist				1	1	Gilchrist					0
Glades					0	Glades					0
Gulf					0	Gulf					0
Hamilton					0	Hamilton					0
Hardee					0	Hardee					0
Hendry	2				2	Hendry					0
Hernando					0	Hernando	1	2			3
Highlands					0	Highlands	1	1		1	3
Hillsborough			1	2	3	Hillsborough	4	5		9	18
Holmes					0	Holmes					0
Indian River	1				1	Indian River		1			1
Jackson					0	Jackson					0
Jefferson					0	Jefferson					0
Lafayette					0	Lafayette					0
Lake	1		1		2	Lake	2	2			4
Lee	4	1			5	Lee	1	1		1	3
Leon				1	1	Leon		2		2	4
Levy					0	Levy					0
Liberty					0	Liberty					0
Madison					0	Madison					0
Manatee	1				1	Manatee		1		2	3
Marion					0	Marion	1				1
Martin	1				1	Martin		1		2	3
Miami-Dade		1		2	3	Miami-Dade	1			5	6
Monroe					0	Monroe					0
Nassua					0	Nassua		1			1
Okaloosa					0	Okaloosa					0
Okeechobee					0	Okeechobee					0
Orange	2	1	2	1	6	Orange	4	3		5	12
Osceola	1				1	Osceola	2			1	3
Palm Beach	1			1	2	Palm Beach	1	3		8	12
Pasco			1		1	Pasco	2	2	2	3	9
Pinellas		3	2	1	6	Pinellas	1	5		5	11
Polk	1		1	1	3	Polk	6	8	1	11	26
Putnam		1			1	Putnam	1	1			2
St Johns		1			1	St Johns		1		1	2
St Lucie	1	1			2	St Lucie		1			1
Santa Rosa					0	Santa Rosa	1				1
Sarasota	2				2	Sarasota				1	1
Seminole				1	1	Seminole	1	1		1	3
Sumter		1			1	Sumter	1			1	2
Suwanee					0	Suwanee					0
Taylor					0	Taylor					0
Union					0	Union					0
Volusia	2				2	Volusia	2	4		3	9
Wakulla					0	Wakulla					0
Walton					0	Walton				1	1
Washington					0	Washington					0
Total	31	14	14	16	75	Total	42	66	5	94	207

The above figures do not include child deaths for which the cause of death was listed as undetermined, unknown, or missing. Most of these were non-verified maltreatment deaths; however there were two verified maltreament deaths (1 in Pinellas and 1 in Seminole) whose cause of death was undetermined.

Table G-2: Distribution of All Child Maltreatment Deaths Across Florida Counties by Primary Cause of Death

County	Primary Cause of Death						
	Drowning	Asphyxia	Weapon	Other	Undetermined	Unknown	Total
Alachua	0	1	0	1	2	0	4
Baker	0	0	0	0	0	0	0
Bay	0	0	0	0	0	0	0
Bradford	0	0	0	0	0	0	0
Brevard	1	5	1	5	0	1	13
Broward	7	2	0	11	5	2	27
Calhoun	0	0	0	0	0	0	0
Charlotte	2	0	0	0	0	1	3
Citrus	3	1	0	0	0	0	4
Clay	1	2	0	2	0	0	5
Collier	1	0	0	0	0	0	1
Columbia	0	0	1	3	1	0	5
DeSoto	0	0	0	0	0	1	1
Dixie	0	0	0	0	0	0	0
Duval	4	12	6	12	2	0	36
Escambia	1	1	0	2	0	0	4
Flagler	0	0	0	0	0	0	0
Franklin	0	0	0	0	0	0	0
Gadsden	0	0	0	0	0	0	0
Gilchrist	0	0	0	1	0	0	1
Glades	0	0	0	0	0	0	0
Gulf	0	0	0	0	0	0	0
Hamilton	0	0	0	0	0	0	0
Hardee	0	0	0	0	0	0	0
Hendry	2	0	0	0	0	0	2
Hernando	1	2	0	0	0	0	3
Highlands	1	1	0	1	0	0	3
Hillsborough	4	5	1	11	5	2	28
Holmes	0	0	0	0	0	0	0
Indian River	1	1	0	0	1	0	3
Jackson	0	0	0	0	0	0	0
Jefferson	0	0	0	0	0	0	0
Lafayette	0	0	0	0	0	0	0
Lake	3	2	1	0	1	0	7
Lee	5	2	0	1	0	0	8
Leon	0	2	0	3	0	0	5
Levy	0	0	0	0	1	0	1
Liberty	0	0	0	0	0	0	0
Madison	0	0	0	0	0	0	0
Manatee	1	1	0	2	1	0	5
Marion	1	0	0	0	0	0	1
Martin	1	1	0	2	1	0	5
Miami-Dade	1	1	0	7	0	0	9
Monroe	0	0	0	0	0	0	0
Nassua	0	1	0	0	0	0	1
Okaloosa	0	0	0	0	0	0	0
Okeechobee	0	0	0	0	0	0	0
Orange	6	4	2	6	9	3	30
Osceola	3	0	0	1	3	1	8
Palm Beach	2	3	0	9	1	0	15
Pasco	2	2	3	3	0	0	10
Pinellas	1	8	2	6	6	0	23
Polk	7	8	2	12	2	0	31
Putnam	1	2	0	0	0	0	3
St Johns	0	2	0	1	1	0	4
St Lucie	1	2	0	0	0	0	3
Santa Rosa	1	0	0	0	0	0	1
Sarasota	2	0	0	1	1	0	4
Seminole	1	1	0	2	3	1	8
Sumter	1	1	0	1	0	0	3
Suwanee	0	0	0	0	0	0	0
Taylor	0	0	0	0	0	0	0
Union	0	0	0	0	0	0	0
Volusia	4	4	0	3	1	1	13
Wakulla	0	0	0	0	0	0	0
Walton	0	0	0	1	1	0	2
Washington	0	0	0	0	0	0	0
Total	73	80	19	110	48	13	343

Information on primary cause of death was missing for six cases where the death incident took place in the following counties: Orange (1), Palm Beach (1), Pasco (2), Polk (1), Seminole (1)

Primary Cause of Death

Table G-3 denotes the distribution of child fatality cases reviewed using the general classification of primary cause of death for those cases verified/non-verified to be the result of child maltreatment. Among the 79 child fatalities verified as a result of maltreatment, 73 (92.4%) resulted from an external injury, 3 (3.7%) due to a medical cause, and 2 (2.5%) were undetermined. These proportions paralleled distributions observed among 2014 cases reported on in 2015. Among those child fatalities non-verified to be the result of abuse and neglect (n=270), a total of 135 (50.0%) were the result of an external injury, 72 (26.7%) were determined to have a medical cause, and 46 (17.0%) had undetermined or unknown cause of deaths.

Table G-3: Primary Cause of Death by Maltreatment Verification Status

Primary Cause of Death	Verified n=79	Non-Verified n=270
External Injury	73	135
Medical Cause	3	72
Undetermined If Injury or Medical	2	46
Unknown or Missing	1	17

Drowning Death Incident Information

Where information was available, Tables G-4, G-5 and G-6 present findings on the location of the child before drowning, activity of child before drowning and drowning location. Among verified maltreatment deaths, a total of 19 (of 31, 61.3%) of the children were playing, four were sleeping and two were bathing before drowning (see Table G-5). Among non-verified maltreatment deaths 80.5% (n=33 of 42) were playing prior to drowning. Among verified maltreatment deaths, prior to drowning, a total of 14 (45.2%) were located in the home and 7 (22.6%) were in the water. All but two (93.5%) of the children whose death was verified as maltreatment and 100% of children whose death was not verified as maltreatment did not know how to swim.

Table G-4: Location of Child Before Drowning by Child Maltreatment Verification Status		
Location of Child Before Drowning	Child Maltreatment Deaths Drowning n=73	
	Verified (n=31)	Non-Verified (n=42)
In Water	7	6
On Shore	0	0
On Dock	0	0
Pool Side	3	5
In Yard	3	12
In Bathroom	6	1
In House	14	18
Other	2	4
Unknown	0	0
Aggregate totals across locations may exceed total number of cases as multiple locations were reported for select cases.		

Table G-5: Activity of Child Before Drowning by Child Maltreatment Verification Status		
Activity Before Drowning	Child Maltreatment Death Drowning n=73	
	Verified (n=31)	Non-Verified (n=42)
Playing	19	33
Boating	0	0
Swimming	1	1
Bathing	2	1
Fishing	0	0
Surfing	0	0
Tubing	0	0
Water Skiing	0	0
Sleeping	4	2
Other	2	2
Unknown	3	3

Table G-6 : Drowning Location by Child Maltreatment Verification Status		
Drowning Location	Child Maltreatment Death Drowning n=73	
	Verified (n=31)	Non-Verified (n=42)
Open Water	6	7
Pool/Hot Tub/Spa	19	32
Bathtub	5	1
Bucket	0	1
Well/Cistern/Septic	0	0
Toilet	1	1
Other	0	0

Sleep-Related Asphyxia Death Incident Information

Table G-7 provides a listing and associated counts of specific objects (including persons) that were reported in a child's sleep environment and for objects identified to have blocked/obstructed a child's airway among the reviewed sleep-related asphyxia cases. The other persons (62 adults, 16 other children) were reported to be in the child's sleep environment among sleep-related asphyxia cases. Twenty-three persons (17 adults and 5 children) were reported to have unintentionally obstructed airways of children who died from sleep-related asphyxia. Bedding (i.e., pillows,

mattresses, comforters/quilts, sheets/thin blankets) was identified to have blocked a child's airway in 53 sleep-related asphyxia cases.

Table G-7: Objects in Sleep Environment Among Sleep-Related Asphyxia Deaths		
	Objects Present in Sleeping Environment	Objects Obstructing Child's Airway
Adult(s)	62	17
Other Children	16	5
Animal(s)	0	0
Mattress	59	13
Comforter	30	12
Thin blanket/flat	44	10
Pillow(s)	52	13
Cushion	8	3
Boppy or U-Shaped Pillow	4	2
Sleep Positioner	2	0
Bumper Pads	1	1
Clothing	4	0
Crib Railing/Side	4	2
Wall	2	0
Toy(s)	2	0
Other	12	7
The above data apply to sleep-related deaths if the child was under the age of five.		

Weapon-Related Death Incident Information

Tables G-8 through G-11 summarize information related to the type of weapon, type of firearm, and the sex of the firearm owner, and sex of person handling the weapon related to the child fatality. Please note, in contrast to the past year's reports, the number of weapon-related deaths reported on for 2015 is likely to increase as the remaining child death reviews (n=125) are completed following the closure of criminal and DCF investigations/services for select 2015 child deaths. For **verified** maltreatment weapon deaths, 4 (28.6%) of weapons used were firearms, 4 (28.6%) were body parts, and 2 (7.1%) were blunt instruments. Among the four firearm deaths, two involved handguns and two involved assault rifles. All of the owners of firearms used in the fatality (for verified maltreatment deaths) were owned by males. When all weapons used in verified maltreatment deaths are considered,12 of 14 (85.7%) were males who handled the weapon that was used in the child's fatality.

Among **non-verified** weapon deaths, 4 (80.0%) of weapons used were firearms, and 1 (20.0%) was a sharp instrument. Among the 4 firearm deaths, all of the firearms were handguns. The owners of firearms used in the fatality were equally likely to be owned by males and females. For 5 of 5 (100%) of verified weapon cases, males handled the weapon used in the child's fatality.

Table G-8: Type of Weapon by Maltreatment Verification Status

Type of Weapon	Child Maltreatment Death Weapons n=19	
	Verified (n=14)	Non-Verified (n=5)
Firearm	4	4
Sharp Instrument	1	1
Blunt Instrument	2	0
Persons Body Part	4	0
Explosive	0	0
Rope	0	0
Pipe	0	0
Biological	0	0
Other	2	0
Unknown	1	0

Table G-9: Type of Firearm by Maltreatment Verification Status

Firearms	Firearm Deaths (n=8) Weapon Type	
	Verified (n=4)	Non-Verified (n=4)
Handgun	2	4
Shotgun	0	0
BB Gun	0	0
Hunting Rifle	0	0
Assault Rifle	2	0
Air Rifle	0	0
Sawed-Off Shotgun	0	0
Other	0	0
Unknown	0	0

Table G-10: Sex of Fatal Firearm Owner by Maltreatment Verification Status		
Sex of Fatal Firearm Owner	Firearm Deaths (n=8)	
	Verified (n=4)	Firearm Deaths (n=4)
Male	4	2
Female	0	2
Unknown	0	0

Table G-11: Sex of Person Handling Weapon by Maltreatment Verification Status		
Sex of Person Handling Weapon	Child Maltreatment Death (n=19)	
	Verified (n=14)	Non-Verified (n=5)
Male	12	5
Female	1	0
Unknown	0	0
Missing	1	0

CHILD CHARACTERISTICS

Age of Child

Table G-12a provides a count of children by age group for which their death was verified as maltreatment by primary cause of death. Table G-12b provides a count of children by age group for which their death was verified as maltreatment and whether the death was classified as abuse or neglect (regardless of primary cause of death). As noted in Table G-12b, 65% (13 of 20) of all abuse deaths and 64.4% (38 of 59) of all neglect deaths happened to children two years of age and younger.

Table G-12a: Age of Children with Verified Maltreatment by Primary Cause of Death and if Death Classified as Abuse or Neglect								
Age	Verified Child Maltreatment Death							
	Drowning n=31		Asphyxia n=14		Weapon n=14		Other n=16	
	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect
< 1	0	2	1	9	4	0	2	5
1	0	9	0	1	3	0	0	0
2	0	5	0	0	1	1	1	3
3	0	4	0	0	0	0	0	1
4	0	4	0	1	1	0	0	1
5	0	3	0	0	0	0	0	1
6-10	1	2	1	0	2	0	0	2
11-15	0	0	0	1	2	0	0	0
16+	0	1	0	0	0	0	0	0
The above data does not include: two verified maltreatment deaths (children <1) classified as neglect where the cause of death was undetermined; one verified abuse death (child <1) with a missing primary cause of death; and, one verified neglect death (1 year old) with a missing primary cause of death.								

Table G-12b: Age of Children with Verified Maltreatment Death Classified as Abuse or Neglect		
Age	Verified Child Maltreatment Death	
	Verified Child Maltreatment n=79	
	Abuse (n=20)	Neglect (n=59)
< 1	8	18
1	3	11
2	2	9
3	0	5
4	1	6
5	0	4
6-10	4	4
11-15	2	1
16+	0	1

Child's History of Victim of Maltreatment

If known and applicable, the distribution of past maltreatment incidents across maltreatment verification status and primary cause of death are denoted in G-13. Please note that for each child identified as a past victim of maltreatment, there may be multiple past maltreatment incidents and/or multiple forms of maltreatment inflicted on the child at one time. There were 75 past maltreatment identifications for the 227 children who died, of which 64% (n=48) were associated with and non-verified child maltreatment deaths.

Table G-13: Child's History as a Victim of Maltreatment for Child Fatality Cases

Type of Past Maltreatment	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning	**Asphyxia**	**Weapon**	**Other**	**Drowning**	**Asphyxia**	**Weapon**	**Other**
	n=27	**n=11**	**n=12**	**n=13**	**n=31**	**n=48**	**n=5**	**n=80**
Physical	7.4%	9.1%	16.7%	0.0%	6.5%	2.1%	40.0%	1.3%
Neglect	40.7%	18.2%	25.0%	23.1%	22.6%	10.4%	40.0%	16.3%
Sexual	0.0%	0.0%	8.3%	0.0%	0.0%	0.0%	20.0%	0.0%
Emotional	3.7%	0.0%	0.0%	0.0%	3.2%	0.0%	40.0%	2.5%

CAREGIVER, SUPERVISOR, AND PERSON(S) RESPONSIBLE CHARACTERISTICS

Table G-14 summarizes the percentage of child fatality cases where one or two caregivers were identified. At least one primary caregiver was identified for all child fatality cases. Among verified maltreatment deaths, between 62.5% ("other" deaths) and 100% (asphyxia deaths) of the children had a second caregiver present in the home. Among non-verified deaths, between 20.0% (weapon deaths) and 83.3% (asphyxia deaths) of the children had a second caregiver present in the home.

Table G-14: Percentage of Cases with One and Two Caregivers Identified as Present by Child Maltreatment Verification Status and Primary Cause of Death

Caregiver Present	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
One	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Two	83.87%	100.00%	92.86%	62.50%	73.81%	83.33%	20.00%	71.28%

Relationship to Child of Caregivers, Supervisors, and Person(s) Responsible for Death

Tables G-15 through G-17 suggest the majority of all caregivers present across all causes of death were the biological parents of the child. Among verified child maltreatment deaths, the proportion of aggregate caregivers who are biological parents ranged from a low of 70% for weapon deaths to a high of 93% for asphyxia deaths. These proportions are generally paralleled for non-verified deaths where the proportion of aggregate caregivers who are biological parents ranged from a low of 82% for drowning deaths to a high of 90% for asphyxia deaths.

These findings are reinforced when examining the distributions of caregiver relationship to child is observed for the first identified caregiver. When the primary relationship of the second caregiver is examined (see Table G-17), only a minority of caregivers in weapons deaths were biological parents with 23% being a step-parent and 23% identified as the mother's partner. Statistical tests of significance of the differences in relationship proportions should be conducted once a larger representative population of 2015 fatality cases has been reviewed.

Table G-15 Relationship to Child of All Identified Caregivers (aggregate) by Maltreatment Verification Status and Primary Cause of Death								
Caregiver Relationship To Child (All Caregivers)	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=57	Asphyxia n=28	Weapon n=27	Other n=26	Drowning n=73	Asphyxia n=121	Weapon n=6	Other n=161
Self	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	75%	93%	70%	81%	82%	90%	83%	85%
Adoptive Parent	4%	0%	0%	0%	0%	2%	17%	0%
Step-Parent	5%	4%	11%	0%	1%	1%	0%	1%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	2%
Mother's Partner	2%	4%	11%	4%	1%	2%	0%	1%
Father's Partner	0%	0%	0%	0%	1%	0%	0%	0%
Grandparent	9%	0%	7%	12%	11%	4%	0%	1%
Sibling	0%	0%	0%	0%	0%	1%	0%	1%
Other Relative	0%	0%	0%	4%	3%	1%	0%	2%
Friend	0%	0%	0%	0%	0%	0%	0%	1%
Institutional Staff	4%	0%	0%	0%	0%	0%	0%	2%
Other	2%	0%	0%	0%	0%	0%	0%	4%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

Table G-16: Relationship to Child of Primary (First) Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death

Caregiver Relationship To Child (Caregiver 1 only)	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
Self	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	87%	100%	93%	81%	93%	97%	80%	87%
Adoptive Parent	3%	0%	0%	0%	0%	2%	20%	0%
Step-Parent	0%	0%	0%	0%	0%	0%	0%	0%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	2%
Mother's Partner	0%	0%	0%	0%	0%	0%	0%	0%
Father's Partner	0%	0%	0%	0%	0%	0%	0%	0%
Grandparent	3%	0%	7%	13%	7%	2%	0%	1%
Sibling	0%	0%	0%	0%	0%	0%	0%	0%
Other Relative	0%	0%	0%	6%	0%	0%	0%	1%
Friend	0%	0%	0%	0%	0%	0%	0%	1%
Institutional Staff	3%	0%	0%	0%	0%	0%	0%	2%
Other	0%	0%	0%	0%	0%	0%	0%	5%
Unknown	3%	0%	0%	0%	0%	0%	0%	0%

Table G-17: Relationship to Child of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death								
Caregiver Relationship To Child (Caregiver 2 only)	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=26	Asphyxia n=14	Weapon n=13	Other n=10	Drowning n=31	Asphyxia n=55	Weapon n=1	Other n=67
Self	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	62%	86%	46%	80%	68%	82%	100%	82%
Adoptive Parent	4%	0%	0%	0%	0%	2%	0%	0%
Step-Parent	12%	7%	23%	0%	3%	2%	0%	3%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	1%
Mother's Partner	4%	7%	23%	10%	3%	4%	0%	3%
Father's Partner	0%	0%	0%	0%	3%	0%	0%	0%
Grandparent	15%	0%	8%	10%	16%	7%	0%	1%
Sibling	0%	0%	0%	0%	0%	2%	0%	1%
Other Relative	0%	0%	0%	0%	6%	2%	0%	4%
Friend	0%	0%	0%	0%	0%	0%	0%	0%
Institutional Staff	4%	0%	0%	0%	0%	0%	0%	1%
Other	0%	0%	0%	0%	0%	0%	0%	1%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

Table G-18 focuses on the relationship of the supervisor of the child at the time of the incident leading to the child's death. Here, some parallels exist with data associated with caregivers (see Table G-15) with some exceptions. Among verified maltreatment deaths, the percentage of supervisors (across primary causes of death) who were biological parents ranges from 54% (for "other" deaths) to 83% (for asphyxia deaths); a majority for each cause of death. Among verified maltreatment weapon deaths, 15% of the supervisors were the mother's partner, with an additional 8% being a stepparent, and 8% being a grandparent. Among verified maltreatment drownings, 17% were the child's grandparent and another 7% involved an "other" relative. Although a large proportion of supervisors associated with asphyxia deaths were biological parents (83%), 8% were identified as friends, and another 8% as institutional staff.

Table G-18: Relationship to Child of Supervisor by Maltreatment Verification Status and Primary Cause of Death								
Supervisor Relationship To Child	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=29	Asphyxia n=12	Weapon n=13	Other n=13	Drowning n=36	Asphyxia n=50	Weapon n=4	Other n=81
Biological Parent	55%	83%	69%	54%	75%	90%	25%	68%
Adoptive Parent	3%	0%	0%	0%	0%	0%	25%	0%
Step-Parent	3%	0%	8%	0%	0%	0%	0%	0%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	1%
Mother's Partner	0%	0%	15%	8%	0%	0%	0%	0%
Father's Partner	0%	0%	0%	0%	0%	0%	0%	0%
Grandparent	17%	0%	8%	15%	14%	2%	0%	5%
Sibling	3%	0%	0%	8%	3%	0%	50%	1%
Other Relative	7%	0%	0%	8%	8%	2%	0%	4%
Friend	3%	8%	0%	0%	0%	0%	0%	2%
Acquaintance	0%	0%	0%	0%	0%	0%	0%	0%
Hospital Staff	0%	0%	0%	8%	0%	0%	0%	6%
Institutional Staff	3%	8%	0%	0%	0%	0%	0%	4%
Babysitter	0%	0%	0%	0%	0%	6%	0%	1%
Licensed Child Care Worker	0%	0%	0%	0%	0%	0%	0%	1%
Other	3%	0%	0%	0%	0%	0%	0%	6%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

For verified child maltreatment deaths, Tables G-19 through G-21 present information on the relationship to the child of the person (or persons) deemed responsible for the child's death. Collectively, biological parents represented those who were person(s) responsible for 64% of drowning, 86% of asphyxia, 57% of weapon, and 72% of other causes deaths. For weapon deaths, 14% of all person(s) responsible and 17% of persons directly causing a child's death were the mother's partner. For weapon death cases, an additional 14% listed a child's stepparent as a person responsible with 8% of cases those who directly caused a weapon's death as a stepparent.

Table G-19: Relationship to Child of All Person(s)s Responsible for Maltreatment Death (aggregate) by Primary Cause of Death				
All Person(s)s Responsible Relationship To Child	Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=14	Weapon n=21	Other n=18
Self	0%	0%	0%	0%
Biological Parent	64%	86%	57%	72%
Adoptive Parent	3%	0%	0%	0%
Step-Parent	3%	0%	14%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	14%	6%
Father's Partner	0%	0%	0%	6%
Grandparent	18%	0%	5%	11%
Sibling	0%	0%	0%	0%
Other Relative	6%	0%	5%	6%
Friend	3%	7%	0%	0%
Acquaintance	0%	0%	0%	0%
Child's Boyfriend/ Girlfriend	0%	0%	0%	0%
Stranger	0%	0%	0%	0%
Medical Staff	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%
Babysitter	0%	0%	0%	0%
Licensed Child Care Worker	0%	0%	0%	0%
Other	3%	7%	5%	0%
Unknown	0%	0%	0%	0%

Table G-20: Relationship to Child of Person who Caused Verified Maltreatment Death by Primary Cause of Death				
Person Responsible - Who Caused Relationship To Child	Verified Child Maltreatment Death			
	Drowning n=6	Asphyxia n=8	Weapon n=12	Other n=13
Self	0%	0%	0%	0%
Biological Parent	83%	88%	58%	77%
Adoptive Parent	0%	0%	0%	0%
Step-Parent	0%	0%	8%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	17%	8%
Father's Partner	0%	0%	0%	8%
Grandparent	0%	0%	0%	0%
Sibling	0%	0%	0%	0%
Other Relative	0%	0%	8%	8%
Friend	0%	0%	0%	0%
Acquaintance	0%	0%	0%	0%
Child's Boyfriend/ Girlfriend	0%	0%	0%	0%
Stranger	0%	0%	0%	0%
Medical Staff	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%
Babysitter	0%	0%	0%	0%
Licensed Child Care Worker	0%	0%	0%	0%
Other	17%	13%	8%	0%
Unknown	0%	0%	0%	0%

Table G-21: Relationship to Child of Person who Contributed to Verified Maltreatment Death by Primary Cause of Death				
Person Responsible - Contributed Relationship To Child	Verified Child Maltreatment Death			
	Drowning n=27	Asphyxia n=6	Weapon n=9	Other n=5
Self	0%	0%	0%	0%
Biological Parent	59%	83%	56%	60%
Adoptive Parent	4%	0%	0%	0%
Step-Parent	4%	0%	22%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	11%	0%
Father's Partner	0%	0%	0%	0%
Grandparent	22%	0%	11%	40%
Sibling	0%	0%	0%	0%
Other Relative	7%	0%	0%	0%
Friend	4%	17%	0%	0%
Acquaintance	0%	0%	0%	0%
Child's Boyfriend/ Girlfriend	0%	0%	0%	0%
Stranger	0%	0%	0%	0%
Medical Staff	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%
Babysitter	0%	0%	0%	0%
Licensed Child Care Worker	0%	0%	0%	0%
Other	0%	0%	0%	0%
Unknown	0%	0%	0%	0%

Average Age of Caregivers, Supervisors and Person(s) Responsible

Table G-22 provides the average ages of caregivers, supervisors, and person(s) responsible for child deaths.

Table G-22: Average Ages of Caregivers, Supervisors, and Person(s) Responsible for Child Fatality by Child Maltreatment Verification Status

Average Age (years)	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning	Asphyxia	Weapon	Other	Drowning	Asphyxia	Weapon	Other
Caregiver1	33.0	28.1	28.1	34.9	32.0	28.2	49.8	31.8
Caregiver2	37.2	31.3	29.9	29.9	40.1	31.8	50.0	33.7
All Caregivers	34.9	29.7	29.0	33.0	35.4	29.8	49.8	32.6
Supervisors	36.8	30.8	28.8	34.8	33.4	28.6	39.0	32.2
Person Responsible - Caused	36.3	26.3	27.0	33.2	NA	NA	NA	NA
Person Responsible - Contributed	37.8	33.7	29.3	38.8	NA	NA	NA	NA
All Person(s) Responsible	37.5	29.4	28.0	34.7	NA	NA	NA	NA

Gender of Caregivers, Supervisors and Person(s) Responsible for Death

Observation of information summarized in Table G-23 reveals that the majority of caregivers for children (across all primary cause of death categories) were female. Among verified maltreatment deaths, between 52% (for weapon deaths) and 69% (for other deaths) of caregivers were female. Among supervisors of verified child maltreatment deaths, 73% of asphyxia cases, 75% of other deaths, and 86% drowning cases were females (Table G-24). The exception to this gender trend was found with verified and non-verified deaths involving weapons. Here, 69% and 75% of the supervisors associated with v3erified and non-verified maltreatment deaths (respectively) were males. Among person(s) responsible (either caused or contributed to) the child's death among verified maltreatment deaths, a large majority of drowning deaths (88%) and other deaths (78%), and the majority of asphyxia deaths (64%) were women (Table G-25). However, the person(s) responsible for the majority of weapon deaths (71%) were male.

Table G-23: Gender of All Identified Caregivers (aggregate) by Maltreatment Verification Status and Primary Cause of Death								
Caregiver Gender	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=57	Asphyxia n=28	Weapon n=27	Other n=26	Drowning n=73	Asphyxia n=120	Weapon n=6	Other n=161
Male	37%	46%	48%	31%	41%	40%	33%	37%
Female	63%	54%	52%	69%	59%	60%	67%	62%
Unknown	0%	0%	0%	0%	0%	0%	0%	1%

Table G-24: Gender of Supervisors by Maltreatment Verification Status and Primary Cause of Death								
Supervisor Gender	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=29	Asphyxia n=11	Weapon n=13	Other n=12	Drowning n=36	Asphyxia n=50	Weapon n=4	Other n=74
Male	14%	27%	69%	25%	33%	22%	75%	23%
Female	86%	73%	31%	75%	67%	78%	25%	77%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

Table G-25: Gender of All Identified Person(s) Responsible for Verified Maltreatment Death by Primary Cause of Death				
All Person(s) Responsible	Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=14	Weapon n=21	Other n=18
Male	12%	36%	71%	22%
Female	88%	64%	29%	78%
Unknown	0%	0%	0%	0%

Substance Abuse History of Caregivers, Supervisors and Person(s) Responsible for Child's Death

Tables G-26 through G-28 summarize information related to substance abuse history of all caregivers, supervisors and person(s) responsible.

Findings from Table G-26 reveal that among the caregivers of children whose deaths were verified as child maltreatment, 56 of 142 (39.4%) are known to have a substance abuse history. A total of 121 of 349 (35%) of caregivers of children whose death was not verified to result from child maltreatment.

Table G-26: Substance Abuse History of All Identified Caregivers of Children by Maltreatment Verification Status and Primary Cause of Death

	Verified Child Maltreatment Death (n=142)				Non-Verified Child Maltreatment Death (n=349)			
Substance Abuse History	Drowning n=55	Asphyxia n=28	Weapon n=23	Other n=26	Drowning n=72	Asphyxia n=118	Weapon n=6	Other n=153
Yes	33%	68%	22%	54%	18%	49%	0%	33%
No	55%	21%	48%	42%	56%	44%	67%	56%
Unknown	13%	11%	30%	4%	26%	7%	33%	12%
	If Yes, Verified Child Maltreatment Deaths (n=56)				**If Yes, Non-Verified Child Maltreatment Death (n=121)**			
Type of Substance	Drowning n=18	Asphyxia n=19	Weapon n=5	Other n=14	Drowning n=13	Asphyxia n=58	Weapon n=0	Other n=50
Alcohol	44%	74%	0%	36%	23%	14%	0%	14%
Cocaine	22%	16%	20%	21%	15%	26%	0%	24%
Marijuana	44%	47%	40%	64%	85%	84%	0%	74%
Methamphetamine	17%	0%	0%	7%	0%	7%	0%	4%
Opiates	33%	16%	20%	21%	15%	14%	0%	24%
Prescription	56%	26%	20%	7%	0%	10%	0%	12%
Over-the-Counter Drugs	0%	0%	0%	0%	0%	0%	0%	2%
Other	22%	11%	0%	29%	23%	12%	0%	22%
Unknown	17%	0%	20%	0%	0%	2%	0%	2%

When types of substances are examined among caregivers with a substance abuse history, among verified drowning maltreatment deaths the substances most prevalent included prescription drugs (56%), alcohol (44%), and marijuana (44%). In addition, one third (33%) of caregivers were found to have a history of opiate abuse. Alcohol abuse (74%) followed by marijuana (47%) and prescription drug abuse (26%) were most represented with verified asphyxia maltreatment deaths. Further, the majority (64%) of caregivers associated with other verified maltreatment deaths had a history with marijuana use. Among non-verified maltreatment deaths, marijuana use by caregivers was identified with an overwhelming majority of deaths with respect to drowning (85%), asphyxia (84%), and other (74%) deaths.

When the substance abuse history of supervisors of children at the time of the child's death is examined (see Table G-27), 49% (n=31 of 63) and 34% (n=53 of 158) of supervisors in verified and non-verified deaths (respectively) were known to have a substance abuse history.[1] Again, given that there are 125 2015 child fatality cases that are still open and/or require local committee review, the above percentages should be considered estimates of the prevalence of substance abuse histories among supervisors involved in child fatalities.

[1] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of supervisors with a substance abuse history for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths WAS statistically significant (Z-Score=2.165, p=.03).

Table G-27: Substance Abuse History of Supervisors of Children at Time of Death by Maltreatment Verification Status and Primary Cause of Death								
Drug Abuse Supervisor	Verified Child Maltreatment Death (n=63)				Non-Verified Child Maltreatment Death (n=158)			
	Drowning n=28	Asphyxia n=11	Weapon n=12	Other n=12	Drowning n=35	Asphyxia n=49	Weapon n=4	Other n=70
Yes	43%	82%	25%	58%	29%	45%	0%	30%
No	50%	18%	58%	33%	57%	51%	100%	60%
Unknown	7%	0%	17%	8%	14%	4%	0%	10%
	If Yes, Verified Child Maltreatment Deaths (n=31)				**If Yes, Non-Verified Child Maltreatment Death (n=53)**			
Type of Substance	Drowning n=12	Asphyxia n=9	Weapon n=3	Other n=7	Drowning n=10	Asphyxia n=22	Weapon n=0	Other n=21
Alcohol	42%	56%	0%	43%	20%	18%	0%	14%
Cocaine	17%	22%	33%	29%	20%	18%	0%	14%
Marijuana	50%	56%	33%	71%	80%	86%	0%	67%
Methamphetamine	25%	0%	0%	14%	0%	14%	0%	0%
Opiates	33%	22%	0%	14%	20%	14%	0%	24%
Prescription	58%	44%	0%	14%	0%	9%	0%	14%
Over-the-Counter Drugs	0%	0%	0%	0%	0%	0%	0%	0%
Other	17%	22%	0%	43%	20%	14%	0%	24%
Unknown	0%	0%	33%	0%	0%	5%	0%	0%

When types of substances are examined (for those with a substance abuse history), the results parallel many of the observations made with caregivers. Among verified drowning maltreatment deaths, the substances most prevalent included prescription drugs (58%), marijuana (50%), and alcohol (42%). In addition, one third (33%) of caregivers were found to have a history of opiate abuse. Alcohol (56%) and marijuana (56%) followed by prescription drug abuse (44%) were most represented with verified asphyxia maltreatment deaths. Further, the majority (71%) of caregivers associated with other verified maltreatment deaths had a history with marijuana use. Among non-verified maltreatment deaths, marijuana use by caregivers was identified with an overwhelming majority of deaths with respect to drowning (80%), asphyxia (86%), and other (67%) deaths.

Table G-28 summarizes information related to substance abuse history of all person(s) deemed responsible (caused and contributed) for the child's death. Findings from Table G-28 reveal that among the person(s) responsible for the child's death whose death was verified as child maltreatment, 51.0% (42 of 82) are known to have a substance abuse history. Substance abuse was identified to be present among 79% of those person(s) responsible for asphyxia deaths, 41% of drowning deaths, 67% of "other" causes of death, and 33% of weapons deaths. Please note that the substance abuse history of 28% of those persons responsible for weapons-related deaths was not known. When types of substances are examined, the majority (or near majority) of those responsible for the child's death verified as maltreatment used marijuana from a low of 46% for drowning deaths to high of 67% of "other" causes of death. Alcohol abuse was prevalent for the majority of persons responsible for asphyxia (55%) and "other" (50%) verified child maltreatment deaths. Further, the majority (62%) of all person(s) responsible for a child's drowning death had an identified history of prescription drug abuse.

Table G-28: Substance Abuse History of All Person(s) Responsible for Child's Death by Maltreatment Verification Status and Primary Cause of Death				
All Person(s) Responsible	Verified Child Maltreatment Death (n=82)			
	Drowning n=32	Asphyxia n=14	Weapon n=18	Other n=18
Yes	41%	79%	33%	67%
No	50%	21%	39%	28%
Unknown	9%	0%	28%	6%
	If Yes, Verified Child Maltreatment Deaths (n=42)			
Type of Substance	Drowning n=13	Asphyxia n=11	Weapon n=6	Other n=12
Alcohol	31%	55%	0%	50%
Cocaine	15%	27%	17%	33%
Marijuana	46%	55%	50%	67%
Methamphetamine	23%	0%	0%	8%
Opiates	38%	27%	0%	17%
Prescription	62%	45%	0%	17%
Over-the-Counter Drugs	0%	0%	0%	0%
Other	23%	27%	17%	42%
Unknown	0%	0%	17%	0%

Disability or Chronic Illness Occurrence among Caregivers, Supervisors and Person(s) Responsible for Death

Tables G-29 through G-31 highlight the distribution of caregivers, supervisors and person(s) responsible known to have an identified disability or chronic illness.

Among all caregivers in deaths verified to have resulted from maltreatment, 12% (16 of 134) were known to have an identified disability or chronic illness of which 6 (or 37.5%) were associated with drowning deaths (Table G-29). Among all caregivers associated with non-verified maltreatment deaths, 9% (30 of 348) were known to have an identified disability or chronic illness.[2]

Table G-29: Presence of Disability or Chronic Illness for All Caregivers by Maltreatment Verification Status and Primary Cause of Death

Disability All Caregivers	Verified Child Maltreatment Death (n=134)				Non-Verified Child Maltreatment Death (n=348)			
	Drowning n=56	Asphyxia n=27	Weapon n=27	Other n=24	Drowning n=70	Asphyxia n=120	Weapon n=6	Other n=152
Yes	11%	15%	15%	8%	9%	8%	33%	9%
No	75%	85%	63%	92%	63%	80%	33%	78%
Unknown	14%	0%	22%	0%	29%	13%	33%	14%
	If Yes, Verified Child Maltreatment Deaths (n=16)				**If Yes, Non-Verified Child Maltreatment Death (n=30)**			
Type of Disability	Drowning n=6	Asphyxia n=4	Weapon n=4	Other n=2	Drowning n=6	Asphyxia n=9	Weapon n=2	Other n=13
Physical	67%	0%	100%	0%	50%	56%	100%	23%
Mental	33%	100%	25%	100%	33%	56%	0%	85%
Sensory	0%	0%	25%	0%	17%	0%	0%	0%
Unknown	0%	0%	0%	0%	0%	11%	0%	0%

When findings from Table G-30 are examined, 13 of 64 (20.0%) supervisors of children whose death was verified to result from maltreatment were identified as having a disability or chronic illness and was statistically significantly higher than the 14 of 158 (9.0%) of supervisors of children whose deaths were not classified as maltreatment.[3] For both verified and non-verified maltreatment deaths, physical disabilities among supervisors were prevalent in the majority of drowning and weapons deaths, whereas mental disabilities were more prevalent in asphyxia and (for verified cases) and asphyxia and "other" deaths for non-verified cases. However, as noted earlier, given the small number of supervisors identified with disabilities and the number of 2015 cases still to be reviewed, these findings should be considered tentative estimates.

[2] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of caregivers with an identified disability or chronic illness for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths was NOT statistically significant (Z-Score=1.11, p=.267).

[3] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of supervisors with an identified disability or chronic illness for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths WAS statistically significant (Z-Score=2.37, p=.019).

Table G-30: Presence of Disability or Chronic Illness for Supervisors by Maltreatment Verification Status and Primary Cause of Death								
Disability or Chronic Illness?	Verified Child Maltreatment Death (n=64)				Non-Verified Child Maltreatment Death (n=158)			
	Drowning n=29	Asphyxia n=11	Weapon n=13	Other n=11	Drowning n=35	Asphyxia n=50	Weapon n=4	Other n=69
Yes	21%	27%	15%	18%	9%	10%	25%	7%
No	66%	73%	62%	82%	77%	88%	75%	83%
Unknown	14%	0%	23%	0%	14%	2%	0%	10%
	If Yes, Verified Child Maltreatment Deaths (n= 13)				If Yes, Non-Verified Child Maltreatment Death (n=14)			
Type of Disability	Drowning n=6	Asphyxia n=3	Weapon n=2	Other n=2	Drowning n=3	Asphyxia n=5	Weapon n=1	Other n=5
Physical	67%	0%	100%	0%	67%	20%	100%	20%
Mental	0%	100%	100%	0%	33%	80%	0%	80%
Sensory	0%	0%	0%	50%	0%	0%	0%	0%
Unknown	0%	0%	0%	0%	0%	20%	0%	0%

Table G-31 summarizes information related to the presence of a disability or chronic illness history of all person(s) deemed responsible (caused and contributed) for the child's death.

Table G-31: Presence of Disability or Chronic Illness for Person(s) Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
Disability or Chronic Illness? (n=85)	Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=14	Weapon n=21	Other n=17
Yes	21%	29%	19%	18%
No	67%	71%	57%	82%
Unknown	12%	0%	24%	0%
	If Yes, Person(s) Responsible Verified Child Maltreatment Deaths (n=18)			
Type of Disability	Drowning n=7	Asphyxia n=4	Weapon n=4	Other n=3
Physical	57%	0%	75%	33%
Mental	43%	100%	25%	100%
Sensory	0%	0%	25%	0%
Unknown	86%	75%	75%	67%

Employment Status of Caregivers

Employment status was examined for all identified caregivers. Tables G-32 through G-34 provide information on the distribution of the caregiver employment status. Table G-32 aggregates all caregivers (whether identified as the first or second primary caregiver), whereas Tables G-33 and G-34 breakdown the distribution of caregiver employment status as the first or second listed primary caregiver.

Table G-32: Employment Status of All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death

Employment - All Caregivers	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=57	Asphyxia n=28	Weapon n=27	Other n=24	Drowning n=72	Asphyxia n=121	Weapon n=6	Other n=159
Employed	61%	57%	41%	54%	54%	46%	83%	47%
Unemployed	23%	21%	26%	21%	10%	21%	17%	22%
On Disability	2%	0%	7%	4%	0%	2%	0%	1%
Stay-at-Home Caregiver	5%	11%	15%	4%	13%	8%	0%	8%
Retired	0%	0%	0%	4%	6%	1%	0%	0%
Unknown	9%	11%	11%	13%	18%	21%	0%	23%

Table G-33: Employment Status of Primary (First) Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death

Employment - Caregiver1	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=15	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=92
Employed	52%	21%	50%	47%	50%	39%	80%	37%
Unemployed	32%	36%	21%	20%	10%	24%	20%	32%
On Disability	0%	0%	0%	7%	0%	3%	0%	0%
Stay-at-Home Caregiver	10%	21%	21%	7%	19%	14%	0%	14%
Retired	0%	0%	0%	7%	2%	0%	0%	0%
Unknown	6%	21%	7%	13%	19%	20%	0%	17%

Table G-34: Employment Status of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death								
Employment - Caregiver2	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=26	Asphyxia n=14	Weapon n=13	Other n=9	Drowning n=30	Asphyxia n=55	Weapon n=1	Other n=67
Employed	73%	93%	31%	67%	60%	55%	100%	60%
Unemployed	12%	7%	31%	22%	10%	18%	0%	9%
On Disability	4%	0%	15%	0%	0%	0%	0%	1%
Stay-at-Home Caregiver	0%	0%	8%	0%	3%	2%	0%	0%
Retired	0%	0%	0%	0%	10%	2%	0%	0%
Unknown	12%	0%	15%	11%	17%	24%	0%	30%

Education Level of Caregivers

Information on the education level of the caregivers was either unknown or not available for the majority of caregivers across maltreatment verification and primary cause of death categories (Table G-35). Where caregiver education level was documented, high school or less than high school education was the most frequently reported. This observation parallels observations noted in the 2015 report (on 2014 cases). Given these findings, it is suggested that efforts be made in future reviews to explore data sources that can provide this information so that more representative conclusions can be made.

Table G-35: Education Level of All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death								
Education - All Caregivers	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=57	Asphyxia n=28	Weapon n=25	Other n=26	Drowning n=72	Asphyxia n=121	Weapon n=6	Other n=159
Less than High School	19%	21%	8%	27%	11%	18%	0%	12%
High School	23%	7%	32%	8%	17%	32%	33%	26%
College	5%	0%	12%	15%	13%	13%	17%	13%
Post Graduate	2%	0%	0%	0%	0%	0%	0%	3%
Unknown	51%	71%	48%	50%	60%	36%	50%	47%

English Spoken by Caregivers, Supervisors, and Person(s) Responsible for Death

As can be observed from information detailed in Tables G-36 through G-38, the vast majority of all caregivers, supervisors, and person(s) responsible for deaths could speak English.

Table G-36: English Speaking by All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death								
Can Caregiver Speak English- All Caregivers	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=56	Asphyxia n=28	Weapon n=27	Other n=26	Drowning n=72	Asphyxia n=114	Weapon n=6	Other n=158
Yes	84%	93%	81%	100%	99%	98%	100%	92%
No	16%	4%	7%	0%	1%	0%	0%	5%
Unknown	0%	4%	11%	0%	0%	2%	0%	3%

Table G-37: English Speaking Ability All Identified Supervisors by Maltreatment Verification Status and Primary Cause of Death								
Can Supervisor Speak English	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=28	Asphyxia n=11	Weapon n=13	Other n=12	Drowning n=36	Asphyxia n=47	Weapon n=4	Other n=73
Yes	82%	91%	77%	100%	97%	100%	100%	93%
No	14%	9%	8%	0%	3%	0%	0%	5%
Unknown	4%	0%	15%	0%	0%	0%	0%	1%

Table G-38: English Speaking Ability All Identified Person(s) Responsible for Verified Maltreatment Death by Primary Cause of Death				
All Persons Responsible English	Verified Child Maltreatment Death			
	Drowning n=32	Asphyxia n=14	Weapon n=21	Other n=18
Yes	81%	93%	90%	100%
No	19%	7%	5%	0%
Unknown	0%	0%	5%	0%

Active Duty Military Status of Caregivers, Supervisors and Person(s) Responsible for Death

One of the core data elements the statewide committee requested to be reported on by the local committees was whether any caregivers, supervisors, and person(s) responsible for the death of a child were on active duty military. Among all caregivers, there were nine caregivers (three verified and six non-verified) who were on active duty military for which six were identified as the second caregiver. Of the three verified maltreatment deaths, two were weapons deaths and one was asphyxia.

Among supervisors of children at the time of the death, there was one identified person on active duty military for an asphyxia death verified as child maltreatment. Further, there were two supervisors of non-verified asphyxia deaths that were on active duty military. When information related to person(s) responsible for a maltreatment fatality is examined,

three individuals were identified as being on active duty military for two verified weapons and one verified asphyxia deaths.

Caregiver Receipt of Social Services in the Past Twelve Months

Local committees were asked to identify from available sources of information the extent to which caregivers had received social services in the twelve months prior to the child's death. Examination of this information is not meant to stigmatize anyone receiving social services. Rather, it can be a potential indicator of environmental stresses and may help identify possible venues for outreach involving future prevention initiatives. Table G-39 summarizes information related to social services receipt among all caregivers (aggregate) identified and reported on for this data element. Please note (as with all measures of combined/aggregate caregivers) that the number of caregivers denoted in Table G-39 exceeds the number of child fatalities as the majority of children had two identified caregivers. Table G-39 first identifies the number of caregivers (associated with verified maltreatment deaths and non-verified) that received social services and then further identifies the specific type of support services received. Please note that with respect to the type of support received, the column percentages (which relate to the total caregivers associated with each primary cause of death) may exceed 100% as caregivers may receive more than one type of service/support over the course of twelve months.

Table G-39: Receipt of Social Services by All Identified Caregivers of Children by Maltreatment Verification Status and Primary Cause of Death

	Verified Child Maltreatment Death (n=137)				Non-Verified Child Maltreatment Death (n=347)			
Receipt of Social Services	Drowning n=57	Asphyxia n=27	Weapon n=27	Other n=26	Drowning n=71	Asphyxia n=117	Weapon n=6	Other n=153
Yes	21%	44%	33%	38%	17%	36%	17%	28%
No	42%	15%	26%	0%	37%	20%	50%	22%
Unknown	37%	41%	41%	62%	46%	44%	33%	50%
	If Yes, Verified Child Maltreatment Deaths (n= 43)				**If Yes, Non-Verified Child Maltreatment Death (n=98)**			
Type of Support	Drowning n=12	Asphyxia n=12	Weapon n=9	Other n=10	Drowning n=12	Asphyxia n=42	Weapon n=1	Other n=43
WIC	17%	58%	44%	20%	8%	67%	0%	28%
TANF	42%	17%	0%	20%	0%	7%	100%	12%
Medicaid	92%	75%	67%	90%	67%	81%	100%	81%
Food Stamps	75%	50%	78%	40%	42%	60%	100%	51%
Other	17%	8%	11%	20%	33%	12%	0%	16%
Unknown	0%	0%	0%	10%	0%	0%	0%	0%

It is important to note that there were a significant number of caregivers across each primary cause of death for which receipt status of social services could not be identified (see first listed "unknown" row category in Table G-39). Thus, the findings presented on these data elements should be considered conservative estimates. Regardless, findings from Table G-39 reveal that among the caregivers of children whose death was verified as child maltreatment, 31% (43 of 137) are known to have received some form of social service support in the twelve months prior to the child's death. This rate approximated the 28.2% (98 of 347) of caregivers of children whose death was not verified to result from child maltreatment. When types of services received is examined across primary cause of the child's death, the vast majority of all caregivers of children whose death was verified as maltreatment received Medicaid (from a low of 67% for weapons deaths to high of 92% for drowning deaths). The majority of all caregivers of children whose death

was not verified as resulting from maltreatment also received Medicaid (from a low of 67% for drowning deaths to a high of 100% for the one weapon death).

In addition to the receipt of Medicaid, among known cases where social service support was received and where maltreatment was verified, the majority of caregivers of children who drowned (75%) and the majority of caregivers of children who died from asphyxia (50%) and weapons deaths (78%) received food stamps.

It is important to note that for year 2015, 49% of mothers who delivered infants participated in WIC and approximately 48.8% deliveries were funded by Medicaid (Florida CHARTS, 2016). Therefore, this data series may be reflective of similar social service receipt occurrences that exist in the general population.

Past History as Victim of Child Maltreatment among Caregivers, Supervisors and Person(s) Responsible

Local committees were asked to identify from available sources of information whether caregivers, supervisors, and person(s) responsible for the death of a child were past victims of child maltreatment. Collectively, it was known that 21.6% (26 of 132) of caregivers (Table G-40) of children of verified maltreatment deaths were past child victims of maltreatment. This figure may underestimate the true proportion of caregivers with a history of maltreatment as a child victim as this status was unknown for 25 (or 18.9%) of the total number of caregivers for children where the child's death was verified as maltreatment. The greatest proportion of caregivers (across cause of death categories) for which this history is unknown is for those children who died by "other" causes (32%), followed by those children who died from asphyxia (29%).

Among the caregivers of children whose death was not a verified maltreatment death, 22% (76 of 348) were identified to have been a past victim of child maltreatment.

When past history as a victim of child maltreatment is examined for supervisors (Table G-41) associated with verified maltreatment deaths, it was known that 27% (17 of 63) were past child victims of maltreatment. Among the supervisors of children whose death was not a verified maltreatment death, 22% (35 of 159) are known to have a history of maltreatment as a child victim.

Among those persons responsible for the child's death (Table G-42), 25% (21 of 83) are known to be past child victims of maltreatment.

Table G-40: Past History as Victim of Child Maltreatment for All Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=132)				Non-Verified Child Maltreatment Death (n=348)			
Caregiver Past Victim of Child Maltreatment	Drowning n=55	Asphyxia n=28	Weapon n=27	Other n=22	Drowning n=71	Asphyxia n=116	Weapon n=6	Other n=155
Yes	9%	29%	22%	32%	21%	24%	0%	21%
No	76%	50%	52%	50%	65%	59%	67%	57%
Unknown	15%	21%	26%	18%	14%	16%	33%	21%
	If Yes, Verified Child Maltreatment Deaths (n= 26)				If Yes, Non-Verified Child Maltreatment Death (n=76)			
Type of Maltreatment	Drowning n=5	Asphyxia n=8	Weapon n=6	Other n=7	Drowning n=15	Asphyxia n=28	Weapon n=0	Other n=33
Physical	20%	63%	100%	71%	53%	36%	0%	48%
Neglect	60%	63%	17%	57%	60%	68%	0%	36%
Sexual	40%	38%	17%	43%	33%	11%	0%	30%
Emotional/ Psychological	0%	25%	17%	0%	7%	25%	0%	15%
Unknown	20%	0%	17%	0%	7%	0%	0%	15%

Table G-41: Past History as Victim of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=63)				Non-Verified Child Maltreatment Death (n=159)			
Supervisor Past Victim of Child Maltreatment	Drowning n=28	Asphyxia n=11	Weapon n=13	Other n=11	Drowning n=34	Asphyxia n=49	Weapon n=4	Other n=72
Yes	11%	36%	38%	45%	29%	27%	0%	17%
No	71%	64%	46%	36%	59%	57%	100%	63%
Unknown	18%	0%	15%	18%	12%	16%	0%	21%
	If Yes, Verified Child Maltreatment Deaths (n=17)				If Yes, Non-Verified Child Maltreatment Death (n=35)			
Type of Maltreatment	Drowning n=3	Asphyxia n=4	Weapon n=5	Other n=5	Drowning n=10	Asphyxia n=13	Weapon n=0	Other n=12
Physical	33%	75%	100%	60%	60%	31%	0%	75%
Neglect	33%	50%	60%	20%	60%	69%	0%	33%
Sexual	0%	50%	0%	80%	40%	15%	0%	33%
Emotional/ Psychological	0%	0%	20%	0%	0%	31%	0%	8%
Unknown	0%	25%	0%	20%	10%	0%	0%	0%

Table G-42: Past History as Victim of Child Maltreatment for Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
	Verified Child Maltreatment Death			
All Persons Responsible as Past Victim of Child Maltreatment (n=83)	Drowning n=32	Asphyxia n=14	Weapon n=21	Other n=16
Yes	6%	43%	29%	44%
No	78%	43%	52%	44%
Unknown	16%	14%	19%	13%
	If Yes, Persons Responsible Verified Child Maltreatment Death (n=21)			
Type of Maltreatment	Drowning n=2	Asphyxia n=14	Weapon n=21	Other n=16
Physical	0%	36%	29%	31%
Neglect	0%	36%	10%	25%
Sexual	1%	14%	0%	19%
Emotional/ Psychological	50%	21%	0%	6%
Unknown	100%	29%	24%	38%

Past History as Perpetrator of Child Maltreatment among Caregivers, Supervisors, and Person(s) Responsible for Death

Local committees were asked to identify from available sources and reports whether caregivers, supervisors, and person(s) responsible for a child's death have a past history as a perpetrator of child maltreatment. When the aggregate of caregivers is examined (Table G-43), 35% (47 of 134) of caregivers of children whose death was verified to result from child maltreatment were identified as past perpetrators of child maltreatment. Among identified cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely (apart from weapons deaths) to be neglect, from a low of 83% of caregivers associated with drowning deaths to a high of 100% of caregivers associated with asphyxia deaths.

When the aggregate of caregivers associated with non-verified deaths is examined, 34.9% (81 of 232) were identified as past perpetrators of child maltreatment. Among identified cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely to be neglect, from a low of 77% of caregivers associated with asphyxia deaths to a high of 100% of caregivers associated with weapons deaths.

Table G-43: Past History as Perpetrator of Child Maltreatment for All Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=134)				Non-Verified Child Maltreatment Death (n=232)			
Caregiver Has History as Perpetrator	Drowning n=56	Asphyxia n=28	Weapon n=27	Other n=23	Drowning n=71	Asphyxia n=120	Weapon n=6	Other n=158
Yes	41%	32%	22%	39%	21%	25%	17%	22%
No	54%	64%	59%	57%	73%	68%	83%	67%
Unknown	5%	4%	19%	4%	6%	7%	0%	11%
	If Yes, Verified Child Maltreatment Deaths (n= 47)				If Yes, Non-Verified Child Maltreatment Death (n=81)			
Type of Maltreatment	Drowning n=23	Asphyxia n=9	Weapon n=6	Other n=9	Drowning n=15	Asphyxia n=30	Weapon n=1	Other n=35
Physical	26%	44%	33%	33%	40%	33%	100%	34%
Neglect	83%	100%	17%	89%	80%	77%	100%	86%
Sexual	0%	22%	0%	11%	13%	10%	0%	3%
Emotional/ Psychological	4%	22%	0%	0%	13%	13%	100%	17%
Unknown	9%	0%	0%	0%	0%	0%	0%	6%

When the past history as a perpetrator of supervisors is examined (see Table G-44), 31.7% (20 of 63) of supervisors of children whose death was verified to result from child maltreatment were identified as past perpetrators of child maltreatment. Among identified cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely (excluding weapons related deaths) to be neglect, from a low of 70% (7 of 10) for supervisors associated with drowning deaths to a high of 100% (4 of 4) for supervisors associated with asphyxia and "other" deaths.

When the aggregate of supervisors associated with non-verified deaths is examined, 24.4% (39 of 160) were identified as past perpetrators of child maltreatment[4]. Among identified cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely to be neglect from a low of 78% (7 of 9) of caregivers associated with drowning deaths to a high of 100% (1 of 1) of supervisors associated with weapons deaths.

[4] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of supervisors with a past history as a perpetrator of child maltreatment for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths was NOT statistically significant (Z-Score=1.12, p=.263).

Table G-44: Past History as Perpetrator of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=63)				Non-Verified Child Maltreatment Death (n=160)			
Supervisor Has History as Perpetrator	Drowning n=28	Asphyxia n=11	Weapon n=13	Other n=11	Drowning n=34	Asphyxia n=50	Weapon n=4	Other n=72
Yes	36%	36%	15%	36%	26%	26%	25%	22%
No	57%	64%	69%	55%	68%	70%	75%	67%
Unknown	7%	0%	15%	9%	6%	4%	0%	11%
	If Yes, Verified Child Maltreatment Deaths (n=20)				If Yes, Non-Verified Child Maltreatment Death (n=39)			
Type of Maltreatment	Drowning n=10	Asphyxia n=4	Weapon n=2	Other n=4	Drowning n=9	Asphyxia n=13	Weapon n=1	Other n=16
Physical	0%	50%	50%	0%	22%	23%	100%	44%
Neglect	70%	100%	0%	100%	78%	85%	100%	94%
Sexual	0%	25%	0%	25%	0%	8%	0%	0%
Emotional/ Psychological	10%	25%	0%	0%	11%	15%	100%	6%
Unknown	10%	0%	0%	0%	0%	0%	0%	0%

Table G-45 summarizes information related to the past history of child maltreatment for all persons deemed responsible (caused and contributed) for the child's verified maltreatment death. Findings from Table G-45 reveal that among persons responsible for a child's death 40.5% (34 of 84) were identified to have a past history as a perpetrator of child maltreatment. Among these 34 individuals, 15 (44%) were affiliated with drowning deaths Again across all causes of death, the type of maltreatment inflicted on children in the past was principally neglect, although physical abuse was also evident with the majority (50%) of perpetrators who were responsible for asphyxia deaths.

Table G-45: Past History as Perpetrator of Child Maltreatment for Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
	Verified Child Maltreatment Death			
Persons Responsible Have History as Perpetrator	Drowning n=32	Asphyxia n=14	Weapon n=21	Other n=17
Yes	47%	43%	24%	47%
No	47%	50%	57%	47%
Unknown	6%	7%	19%	6%
	If Yes, Persons Responsible Verified Child Maltreatment Death (n=34)			
Type of Maltreatment	Drowning n=15	Asphyxia n=6	Weapon n=5	Other n=8
Physical	33%	50%	40%	25%
Neglect	80%	83%	0%	100%
Sexual	0%	33%	0%	13%
Emotional/ Psychological	7%	33%	0%	0%
Unknown	7%	0%	0%	0%

Past History of Intimate Partner Violence (as Victim and Perpetrator) among Caregivers and Supervisors

Table G-46 highlights the distribution of caregivers' history with intimate partner violence as a victim and/or perpetrator. In total, 29 caregivers (21.6% of 134) were known to be victims and 20 (14.9% of 134) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths. The primary cause of death with the greatest proportion of caregivers as victims (38%) and perpetrators (25%) were verified maltreatment "other" deaths. Among non-verified deaths, a total of 42 caregivers (11.8% of 357) were known to be victims and 37 (10.4% of 357) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths. Statistical tests suggest that the proportion of caregivers known to be victims of intimate violence among verified child maltreatment deaths is significantly higher than the percentage of caregivers associated with non-verified child maltreatment deaths. However, there was no statistical significance in the proportions of caregivers who were past perpetrators of intimate violence.[5]

[5] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of caregivers with a history as a victim of intimate for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths WAS statistically significant (Z-Score=2.77, p=.0056). The same test was conducted for those with a history as a perpetrator of intimate violence. Observed proportions were NOT statistically significant (Z-score =1.41, p=.16)

Table G-46: History of Intimate Partner Violence with Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=134)				Non-Verified Child Maltreatment Death (n=357)			
History of Intimate Partner Violence	Drowning n=55	Asphyxia n=28	Weapon n=27	Other n=24	Drowning n=73	Asphyxia n=119	Weapon n=6	Other n=159
Yes, as Victim	13%	29%	19%	38%	7%	15%	0%	12%
Yes, as Perpetrator	7%	25%	11%	25%	5%	16%	0%	9%
No	62%	29%	33%	38%	59%	58%	50%	64%
Unknown	20%	25%	37%	8%	32%	15%	50%	19%

Table G-47 highlights the distribution of supervisors' history with intimate partner violence as a victim and/or perpetrator. In total, 12 caregivers (18.8% of 64) were known to be victims and 7 (10.9% of 64) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths. The primary cause of death with the greatest proportion of supervisors as victims (27%) was among asphyxia deaths. Among non-verified deaths, a total of 20 of 163 supervisors (12.3%) were known to be victims and 19 of 163 (11.7%) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths.

Table G-47: History of Intimate Partner Violence with Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=64)				Non-Verified Child Maltreatment Death (n=163)			
History of Intimate Partner Violence	Drowning n=28	Asphyxia n=11	Weapon n=13	Other n=12	Drowning n=36	Asphyxia n=50	Weapon n=4	Other n=73
Yes, as Victim	14%	27%	15%	25%	11%	16%	0%	11%
Yes, as Perpetrator	7%	9%	8%	25%	3%	20%	0%	11%
No	57%	36%	38%	58%	61%	58%	75%	67%
Unknown	25%	27%	38%	0%	28%	12%	25%	16%

Table G-48: Past History of Intimate Partner Violence for Person(s) Responsible for Maltreatment Death (by Maltreatment Verification Status and Primary Cause of Death)				
History of Intimate Partner Violence: Person(s) Responsible	Verified Child Maltreatment Death (n=75)			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=16
Yes, as Perpetrator	6%	14%	21%	25%
Yes, as Victim	16%	14%	21%	31%
No	55%	43%	36%	44%
Unknown	19%	14%	21%	0%

When the history of intimate partner violence is examined for persons responsible for a child's death is examined, among verified maltreatment deaths, information on this data element is unknown for 19%, 14%, and 21% of those responsible for drowning, asphyxia, and weapons respectively. Those with a history as a victim of intimate partner violence ranged from a low of 14% for those responsible for asphyxia deaths to a high of 31% for those responsible for "other" deaths. Those with a history as a perpetrator of intimate partner violence ranged from a low of 6% for those responsible for drowning deaths to a high of 25% for those responsible for "other" deaths.

Past Criminal History of Caregivers, Supervisors, and Person(s) Responsible for Death

When the criminal history of caregivers is examined (Table G-48), among caregivers associated with verified maltreatment deaths, 51 of 137 (37.21%) had committed a criminal offense in the past. This rate is contrasted against 118 of 359 (32.9%) of caregivers of children whose death was not verified as child maltreatment. When primary cause of maltreatment deaths is observed, the highest proportion of caregivers for verified maltreatment cases with a criminal past were those affiliated asphyxia deaths (59%), followed by other causes of deaths (42%), weapons deaths (30%), and drowning deaths (28%). The types of offenses (for verified cases that caregivers committed vary in proportional representation across primary cause of death. Among those with a criminal history, those with drug offenses were represented from a low of 38% for caregivers associated with weapons deaths to a high of 63% of verified asphyxia deaths. The modal type of offenses for caregivers for weapons (100%), drowning (88%), asphyxia (63%), and other causes of death (82%) were offenses "other" than assault, robbery and drugs. Please note that the column totals for the type of offense for across each category of primary cause of death may exceed 100% as individual caregivers may have more than one past criminal offense.

When the criminal history of supervisors is examined (See Table G-49), among supervisors associated with verified maltreatment deaths, 26 of 64 (40.6%) had committed a criminal offense in the past. This rate is significantly higher when contrasted against 47 of 164 (28.7%) of supervisors of children whose death was not verified as child maltreatment.[6] When primary cause of maltreatment deaths is observed, the highest proportion of supervisors for verified maltreatment cases with a criminal past were those affiliated with asphyxia deaths (60%) followed by weapons

[6] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of supervisors with a past criminal history for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths was NOT statistically significant (Z-Score=1.30, p=.194).

deaths (38%). The types of offenses (for verified cases) that supervisors committed vary in proportional representation across primary cause of death. Among those with a criminal history, those with drug offenses were represented from a low of 40% for supervisors associated with verified weapons deaths to a high of 75% of those supervisors associated with "other" deaths. The modal type of offenses for supervisors for drowning (71%), weapons (100%), and other causes of death (100%) were offenses "other" than assault, robbery, and drugs. Please note that the column totals for the type of offense for each category of primary cause of death may exceed 100% as individual caregivers may have more than one past criminal offense.

Table G-49: History of Intimate Partner Violence Known Within Case (as Victim and/or Perpetrator) For Caregivers, Supervisors, and Person(s) Responsible for Death by Maltreatment Verification Status and Primary Cause of Death

	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
IPV History Exists	23%	64%	36%	56%	12%	33%	0%	21%

Table G-50: Past Criminal History of Caregivers by Maltreatment Verification Status and Primary Cause of Death

	Verified Child Maltreatment Death (n=137)				Non-Verified Child Maltreatment Death (n=359)			
Criminal History of Caregivers	Drowning n=57	Asphyxia n=27	Weapon n=27	Other n=26	Drowning n=73	Asphyxia n=121	Weapon n=6	Other n=159
Yes	28%	59%	30%	42%	16%	45%	17%	31%
No	58%	26%	52%	50%	67%	45%	83%	57%
Unknown	14%	15%	19%	8%	16%	10%	0%	11%
	If Yes, Verified Child Maltreatment Deaths (n=51)				If Yes, Non-Verified Child Maltreatment Death (n=118)			
Type of Offense	Drowning n=16	Asphyxia n=16	Weapon n=8	Other n=11	Drowning n=12	Asphyxia n=55	Weapon n=1	Other n=50
Assaults	25%	38%	25%	45%	17%	31%	0%	28%
Robbery	6%	19%	25%	27%	25%	15%	0%	26%
Drugs	63%	56%	38%	55%	50%	64%	0%	30%
Other	88%	63%	100%	82%	67%	62%	100%	76%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

Past Child Death Associated with Caregivers, Supervisors, and Person(s) Responsible for Death

Tables G-51 identifies past child deaths linked to one caregiver associated with a verified drowning death and three caregivers (two first and one second) associated with non-verified asphyxia deaths. When the supervisors of children are examined (see Table G-52), past child deaths are linked to one associated with a verified drowning death and one supervisor associated with non-verified asphyxia deaths. Among those responsible for verified maltreatment deaths (Table G-53), two associated with drowning deaths were linked to past child deaths.

Table G-51: Past Criminal History Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=64)				Non-Verified Child Maltreatment Death (n=164)			
Criminal History of Supervisors	Drowning n=29	Asphyxia n=10	Weapon n=13	Other n=12	Drowning n=36	Asphyxia n=50	Weapon n=4	Other n=74
Yes	24%	60%	38%	33%	17%	48%	0%	23%
No	66%	40%	54%	58%	69%	46%	100%	66%
Unknown	10%	0%	8%	8%	14%	6%	0%	11%
	If Yes, Supervisor of Verified Maltreatment Death (n=26)				If Yes, Supervisors of Non-Verified Child Maltreatment Death (n=47)			
Type of Offense	Drowning n=7	Asphyxia n=10	Weapon n=5	Other n=4	Drowning n=6	Asphyxia n=24	Weapon n=0	Other n=17
Assaults	43%	0%	20%	25%	33%	29%	0%	35%
Robbery	0%	10%	40%	25%	33%	4%	0%	24%
Drugs	43%	60%	40%	75%	67%	58%	0%	18%
Other	71%	50%	100%	100%	67%	71%	0%	76%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

Table G-52: Past Criminal History Associated with All Persons Responsible by Maltreatment Verification Status and Primary Cause of Death				
Criminal History All Persons Responsible (n=86)	Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=14	Weapon n=21	Other n=18
Yes	30%	71%	38%	44%
No	55%	29%	48%	50%
Unknown	15%	0%	14%	6%
	If Yes, Persons Responsible Verified Child Maltreatment Death (n=36)			
Type of Criminal History	Drowning n=10	Asphyxia n=10	Weapon n=8	Other n=8
Assaults	30%	20%	25%	25%
Robbery	0%	20%	38%	38%
Drugs	60%	80%	25%	63%
Other	80%	70%	100%	75%
Unknown	0%	0%	0%	0%

Table G-53: Past Child Death Associated with Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=135)				Non-Verified Child Maltreatment Death (n=355)			
Past Child Death with Caregiver	Drowning n=57	Asphyxia n=28	Weapon n=26	Other n=24	Drowning n=70	Asphyxia n=119	Weapon n=6	Other n=160
Yes	2%	0%	0%	0%	0%	3%	0%	3%
No	96%	100%	88%	100%	89%	97%	100%	91%
Unknown	2%	0%	12%	0%	11%	1%	0%	7%

Table G-54: Past Child Death Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=64)				Non-Verified Child Maltreatment Death (n=162)			
Past Child Death with	Drowning n=29	Asphyxia n=11	Weapon n=13	Other n=11	Drowning n=34	Asphyxia n=50	Weapon n=4	Other n=74
Yes	3%	0%	0%	0%	0%	2%	0%	5%
No	90%	100%	85%	100%	91%	96%	100%	86%
Unknown	7%	0%	15%	0%	9%	2%	0%	8%

Table G-55: Past Child Death Associated with Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
	Verified Child Maltreatment Death			
Past Child Death with Persons Responsible (n=85)	Drowning n=33	Asphyxia n=14	Weapon n=21	Other n=17
Yes	6%	0%	0%	0%
No	88%	100%	86%	100%
Unknown	6%	0%	14%	0%

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State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

June 6, 2017

Dr. Robin Perry, Chairperson
State Child Abuse Death Review Committee
Florida Mechanical and Agricultural University
1339 Wahnish Way
300 Banneker Building B
Tallahassee, FL 32307

Dear Dr. Robin Perry:

Thank you for the opportunity to review and respond to the 2016 State Child Abuse Death Review Committee Report. The Department of Children and Families appreciates the work of both the state and local Child Abuse Death Review Committees and the continued exploration of meaningful efforts to reduce the number of preventable child fatalities.

Below is a summary of on-going activities within the span of our control in response to the recommendations contained in the annual report:

Committee Recommendation: Enhance and support the integration of behavioral health services into the child welfare system.

DCF Response:
The integration of child welfare and behavioral health became one of the Department's Priority of Efforts in June 2015. The work associated with this priority has been primarily focused on the self-study created through the Child Welfare Project Team. The Department created Integration Process and Facilitation Guides to accompany the roll out of the Self-Study across the state. The process guide defines, for the first time in Florida, the integration of child welfare and behavioral health. Each region has been tasked with the formation of local leadership teams and the completion of the self-study. Upon completion of the self-study, a peer review team is assembled with representatives from different parts of the system and an on-site review is conducted. After review of the peer review team report, the local leadership team decides upon a plan of action to move their system of care forward, in alignment with Florida's model.

Committee Recommendation: Continue to support programs that enhance parenting skills.

DCF Response: The Department continues an intentional incorporation of the protective factors throughout policy and practice. The prevention strategies around protective factors include statewide and local initiatives, and is heavily collaborative across various state agencies and other partners. The Department works with Healthy Families Florida, through their evidence-based home-visiting program, to sustain and increase capacity for serving families at high risk of child maltreatment due to domestic violence, substance abuse, and mental health issues.

The Department has recently awarded seven contracts to Community-Based-Care Lead Agencies for the purpose of providing Family Support Services to families whose children have been determined to be at high or very high risk of future maltreatment. Case coordination will occur throughout the life of the case and will be targeted at building a family's protective factors and addressing barriers to long term safety.

Committee Recommendations: (1) Ensure clear and consistent messaging among agencies during efforts to increase awareness. **(2)** Encourage collaborative partnerships at both the state and community levels.

DCF Response: The Department remains steadfast in its commitment to improving messaging, keeping it concise, easy to understand, and aligned with other agencies, as well as the recommendations of the American Academy of Pediatrics. The Department, other state agencies, and nonprofits meet regularly to discuss prevention messaging and more effective and impactful pooling of prevention resources.

The Department works closely with the Ounce of Prevention Fund. The Ounce continues to develop and strengthen community-based programs serving children and families throughout the state, encouraging collaborative efforts at both the community and state levels.

Please extend my gratitude to the committee for their service and dedication in review of child fatalities that are brought to the attention of the agency. The Florida legislature continues to take a leadership role in closely analyzing the many complexities of the state's child protection system as we work in collaboration with our partners to strengthen and enhance our community involvement for the safety of Florida's children. Please feel free to contact me or Erin Hough, Prevention Specialist, at (850) 717-4658 or by email at Erin.Hough@myflfamilies.com if you have any questions or need further information.

Sincerely,

Mike Carroll
Secretary

ANNUAL REPORT

Independent Living Services Advisory Council

Meet Melissa, CBC of Central Florida,
Full Time Student while working through College

2016

TABLE OF CONTENT

Meet Jazzman, Palm Beach County volunteering at a beach clean up event.

Meet program participant from Hands of Mercy Everywhere Inc, Graduating High School.

Meet a future graduate from ROTC in Belleview.

BACKGROUND OVERVIEW

Chafee Foster Care Independence Act (1999)

- Enacted by Federal Government
- Increased state funding to provide teens who "aged out" of foster care system with better access to programs designed to promote the development of self-sufficiency.
- Training for older foster youth for: Education, Preparation for Post Secondary, Daily Life Skills, Employment, Substance Use Services, Pregnancy Prevention, and Preventative Health Activities.
- Connect older foster teens with permanent supportive adults.

Road to Independence Act (2002)

- State-based program establishing a system of independent living transitional services enabling older foster teens who exit foster care at 18 to make the transition to self-sufficiency as adults.
- Provide direct stipend payments to young adults while they pursue full-time education opportunity in areas of continuing education, or vocational training for post-secondary degrees.

Sen. Nancy Detert Common Sense & Compassion Independent Living Act (2013)

- Extends care for foster teens until the age of 21. For youth attending an approved education program full time, or
- Youth must be working a minimum of 80 hours/month, or
- Youth is participating in a program designed to promote or eliminate barriers to employment.

Note: If a youth has a documented disabillity that limits thier ability to work or attend education full time, then the case worker and the youth will create an individualized plan to meet the needs of the youth.

What does effective parenting look like when the State of Florida is the parent of a young adult? For young adults known to the Department of Children and Families (DCF) ages 18-22 years old, this is the question that has been examined, modified, and re-examined since 1999. As a result, the following legislation has evolved over time to give older foster youth the opportunities that most teens have growing up in healthy – supportive homes.

Oversight for the provision of these services is provided in the Florida Statute, under section 409.1451(7),which allows the Secretary of DCF to appoint an independent council to serve the purpose of reviewing and making recommendations concerning the implementation and operation of the provisions of s. 39.6251 and the Road-to-Independence Program.

As a result, the Independent Living Services Advisory Council (THE COUNCIL) was created and has provided oversight for these Independent Living Services and has given feedback and recommendations to DCF as an independent body for the past ten years. THE COUNCIL consists of community members from varying stakeholder agencies who share the same concern and willingness to improve the implementation and operation of the Road-to-Independence Program, while advising DCF on actions that would improve the ability of the

Road-to-Independence Program services to meet the intended goals.

Through this year's report the members of the 2016 COUNCIL pay tribute to the hard work and dedication of previous COUNCIL members. Over the past ten years COUNCIL members have dedicated their time, experience, and commitment to improving child welfare for older foster youth by closely examining challenges and successes related to services provided to this population across the state. A key component of this work is making, and following up on, recommendations made to DCF in key areas related to Independent Living Services.

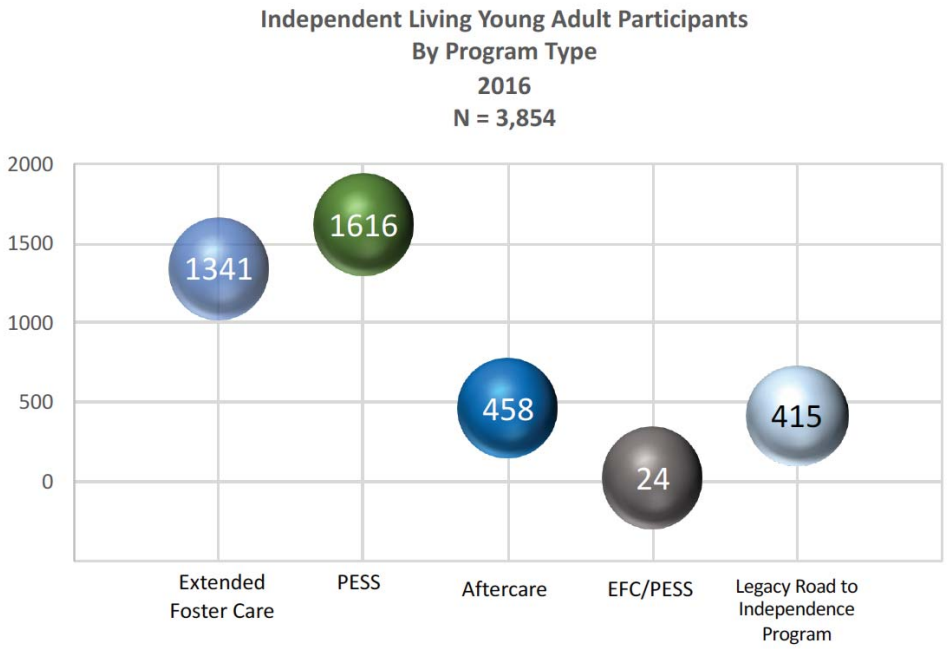
In addition, this report begins a new age for THE COUNCIL. In 2017, a new process will be in place tracking COUNCIL membership, meeting schedules, and content for each meeting that will refocus the efforts on implementation and operation of the service delivery of Road-to-Independence services so that young adults are better prepared for self-sufficiency.

The truth of the matter is that it is difficult for any agency to replace what healthy, supportive, and loving families provide. Over the past 10 years, THE COUNCIL has demonstrated that having an independent body examine what is in place is better than no examination at all. During this time, the youth have demonstrated their resilience to rise above difficult situations and achieve great heights when given the best opportunities to succeed. In the years ahead, THE COUNCIL is committed to ensuring these opportunities are in place for older foster youth so they can begin new chapters of their lives leading toward greater self-sufficiency.

Meet Sandy, Palm Beach County, moving away to college to become a teacher.

Meet Bill, very excited to meet Dwayne Johnson and helping "The Rock on set"

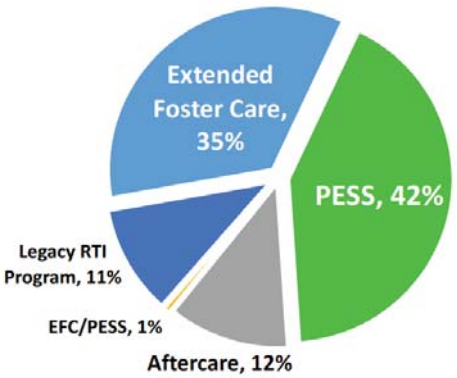
By the Numbers

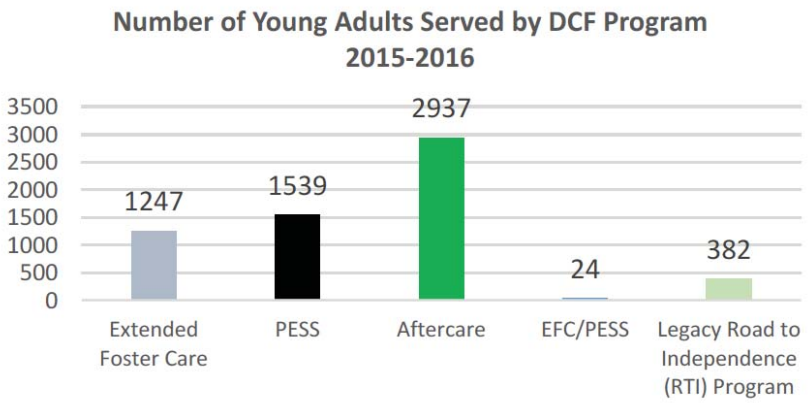


Independent Living Program Participants by Age
18 – 24 year olds
N = 3,854

	18	19	20	21	22	23	Totals	Percent
Extended Foster Care	705	406	180	50	0	0	1341	35%
PESS	123	245	315	370	461	102	1616	42%
Aftercare	115	103	87	79	66	8	458	12%
EFC/PESS	16	5	3	0	0	0	24	1%
Legacy RTI Program	0	30	126	120	107	32	415	11%
Totals	**959**	**789**	**711**	**619**	**634**	**142**	**3854**	**100%**

INDEPENDENT LIVING PROGRAM PARTICIPANTS





Source: DCF 2015 - 2016 FSFN

Executive Summary

THE COUNCIL met monthly from January 2016 through November 15, 2016 to review services, challenges, achievements and programs that are in place to assist older foster youth on their journey toward adulthood and self-sufficiency. Five central areas were identified as critical areas requiring follow-up by DCF. These areas included:

Recommendations Summary

1 Education

1 Require case managers to be knowledgeable about the Multi-Tiered System of Supports.

2 Urge case managers to be knowledgeable of online resources for education and career planning.

3 DCF to pursue a plan to provide funding to maintain a network of post-secondary campus-based support initiatives.

4 Continue collaborating with state leadership to support the work of statewide initiative related to college campus-based supports.

2 Housing

1 Create a tracking system for homeless youth known to DCF that is used statewide.

2 Use existing meetings to provide training statewide about Supportive Housing Programs, Housing Coordination and Host Families.

3 Implement After Care services and funding in uniform fashion holding youth & CBCs accountable to avoid homeless situation.

4 Improve tracking and monitoring of homeless-ness data to accurately capture young adults are formerly from foster care.

3 Teen Parents

1 Increase funding for specialized services, training, and level of care needed so that teen parents in Extended Foster Care can remain in or relocate to quality parenting-driven programs.

2 DCF to propose legislation for 2017 to add judicial follow up to ensure that the expected case plan requirements related to parenting teens are met with in 30 days of hearings.

3 Provide parenting youth in foster care with a Fast Pass allowing young parents access to free, flexible, quality daycare.

4 Employment

1 Develop and adopt operating procedures, definition of common terms and expectations that emphasize employment for older foster youth.

2 Enter into a Data Sharing Agreement with DEO and DOR to receive employment status data for youth in care and provide quarterly updates to THE COUNCIL.

3 Evaluate the current capacity of FSFN, implement necessary system enhancements and program policies to record and track the employment status of all youth who are in care.

4 Youth employment should be included on DCF scorecard as a key component of the system of care and used to promote normalcy for youth in dependency care.

5 Revise Quality Assurance system to evaluate the collection and management of data related to IL youth who are employed.

1 Determine why DCF youth have a lower issuance rate of civil citations by working with local law enforcement agencies (LEA) to dispel any myths they may have about children in foster care, and to resolve any real issues they may have with the child welfare system.

2 Explore with local law enforcement agencies why certain counties do not offer civil citations at all.

3 Determine why DCF youth who are issued a civil citation have a lower successful completion rate, and then explore how to resolve this.

4 DCF should work with DJJ at the state level to ensure there is timely sharing of civil citation cross-over data at both the state and local levels.

Executive Summary Continued

These areas were explored and presented in this report in the following manner:

- Creating a **key question** driving the concern for the service delivery or lack thereof.
- **Taking steps** as a COUNCIL during meetings to get the most accurate information available about the subject area.
- Communicating **findings** from the actions taken by THE COUNCIL.
- Examining critical **data** related to the subject area (if available).
- Creating concrete **recommendations** that can be followed up by DCF and THE COUNCIL in the following year.

One central theme that persisted throughout the year in relation to exploring these critical areas was the availability, or accuracy of data requested by THE COUNCIL from DCF. Data has been provided about enrollment/utilization of the services offered (i.e., how many participants utilize the various services, and the costs associated with providing the benefits). What is unclear is how the participation numbers compare with the overall population of eligible individuals for independent living services. For example: a review of the data showing total participants in each post-foster care program appears to show that the overall headcounts are relatively flat or declining over the reporting period or since the 2014 legislation.

A percentage (year-to-year) of the eligible population utilizing services would provide a better indicator of the penetration and effectiveness of these services (and their associated implementation plans), as opposed to a headcount. This will be an area for future exploration for THE COUNCIL accompanied by future recommendations.

THE COUNCIL would be remiss not to recognize DCF and their efforts to respond to the requests for data and presentations throughout the year. THE COUNCIL greatly appreciates the assistance of the Statewide Independent Living Services Specialist to take requests and reply to them in a timely manner so meetings can have the most accurate information and data available.

Education

KEY QUESTION

How can DCF best support K-20 educational success for youth and young adults in and from foster care and enable them to access and utilize the full range of education-related transition options and resources available to them?

STEPS TAKEN BY COUNCIL

THE COUNCIL has worked this year to educate its members on resources available that will assist youth in foster care to successfully transition to independence by identifying key areas of need, barriers and assets related to educational success, and best practice. This information can enable the state, through its private community-based care providers, sub-contractors, and community agencies, to improve their service to youth in foster care and the many dedicated paraprofessionals, and volunteers who support them.

In the K-12 area, THE COUNCIL received a presentation about the Multi-Tiered System of Supports (MTSS) used by school districts to identify, monitor and assess the needs of students struggling in school, including the many youth in care who struggle because of issues both related to foster care and related to issues they experienced before entering care. The MTSS system is an evidence-based model of academic support that uses data-based problem-solving to integrate academic and behavioral instruction and intervention.

In 2006, the Florida Department of Education and the University of South Florida created the Florida Problem Solving and Response to Intervention (PS/RtI) Project. Through the years, the mission of the project has evolved through a partnership with the Florida Positive Behavioral Interventions and Support (PBIS) into the MTSS initiative. In other words, in Florida RtI is described as a MTSS.

The integrated instruction and intervention is delivered to students in varying intensities (multiple tiers) based on student need. The goal is to prevent problems and intervene early so that students can be successful.

PS/RtI provides professional development, technical assistance and support to increase the implementation and sustainability of a multi-tiered system of supports. This effort is supported by Regional Coordinators (RCs) located in the northern, central, and southern areas of the state. The RCs increase the ability of districts to implement MTSS through training, technical assistance, and support. Professional development modules and materials are created to support MTSS implementation across the state. In addition, project staff support the Florida Department of Education in their work with districts to improve the performance of all students.

According to the PBIS annual report, the organization worked with 54 out of 67 (81%) of Florida's school districts in 2014-2015. Forty-two percent (42%) of trained districts in Florida have trained at least 90% of the schools in their district. Only 17% of districts have trained less than

50% of the district schools. Of the 1723 trained schools, 1504 (87%) were active in the 2014-2015 school year. All elements of training have consistently been rated 5 or higher on a scale of 1 to 6.

Successful use of the MTSS must include families as full participants in the educational process for their children. Families participate as planners, contributors, leaders, teachers, learners, and colleagues. This is especially important for youth in the foster care system. Case managers, foster parents, and group home managers must be knowledgeable about the Multi-Tiered System of Supports and how to work with school personnel to plan interventions to support foster youth struggling in school. The fact that so many Districts throughout the state have received this high quality training enabled THE COUNCIL to make the recommendations that follow.

THE COUNCIL also received a presentation about My Career Shines, a comprehensive education and career planning system that can help foster youth succeed in the increasingly competitive global economy. THE COUNCIL learned, via an in-depth demonstration of the service, how foster youth and all students can learn about themselves, discover the many options and opportunities for their future, and gain access to the information and tools to achieve their goals. My Career Shines is already used by many school districts to satisfy the state's Career and Education Planning Course requirement for middle school students. Subsequent discussion suggested that foster parents, care givers, and case managers could benefit from training and access to this system to help foster youth explore and adjust their Career and Education Plan.

Regarding the post-secondary education arena, THE COUNCIL heard a presentation about Florida Reach from one of its co-founders. Florida Reach is a network of young adults, child welfare workers, youth advocates, representatives of community-based care agencies, and education student support services professionals. The presentation highlighted a number of programs at colleges throughout the state that are working to implement campus-based support initiatives, led by appointed or hired higher education professionals, several of whom also have strong social work backgrounds. The colleges and universities with paid full-time staff focused specifically on young adults from foster care include: Tallahassee Community College, Miami Dade College (2), Valencia College. The university with paid full-time staff are Florida International University (2).

Florida Reach's work has been led by a group of volunteer members of the network. DCF has provided strong moral support for this statewide group of leaders and provided the majority of funding for the 2016 Florida Reach Symposium, which was attended by more than 150 social work and higher education professionals from Florida and other parts of the country. DCF recently released a Request for Proposal that would provide funding for an organization that is willing and able to continue Florida Reach's work and to coordinate, develop, and maintain the Positive Pathways Network, a network of postsecondary campus-based support initiatives across the Florida public college and university system.

Meet Stanley, Adopted at 14 and now age 23. He attends college, and recently completed the EMT Program and works at a Walk-in Clinic.

FINDINGS

Independent living transition services are designed to help foster youth obtain life skills and education so that they can obtain post-secondary credentials that can help ensure they can earn a living and sustain themselves in adulthood. Adolescence is a time of growth, learning, and developing independence, and most youth, with the support of their family, make a successful transition to adulthood. However, youth in the foster care system often lack the guidance, support, and training to learn the skills necessary to function independently when they leave the system.

In addition to struggling in school, youth in care who experience frequent school changes may also have difficulty developing and sustaining supportive relationships with teachers or peers. Supportive relationships and a positive educational experience can be powerful contributors to the development of resilience and are vital components for healthy development and overall well-being.

Research has shown that foster youth often fall behind their peers in educational attainment due to disruptions throughout their educational careers. Youth in foster care are more likely to drop out of school, less likely to receive a high school diploma or a GED, and less likely to participate in postsecondary education. Since educational success is a key to financial self-sufficiency, coordinated educational services are critical to help foster youth succeed academically. Programs that promote educational stability and integration are most likely to promote educational success.

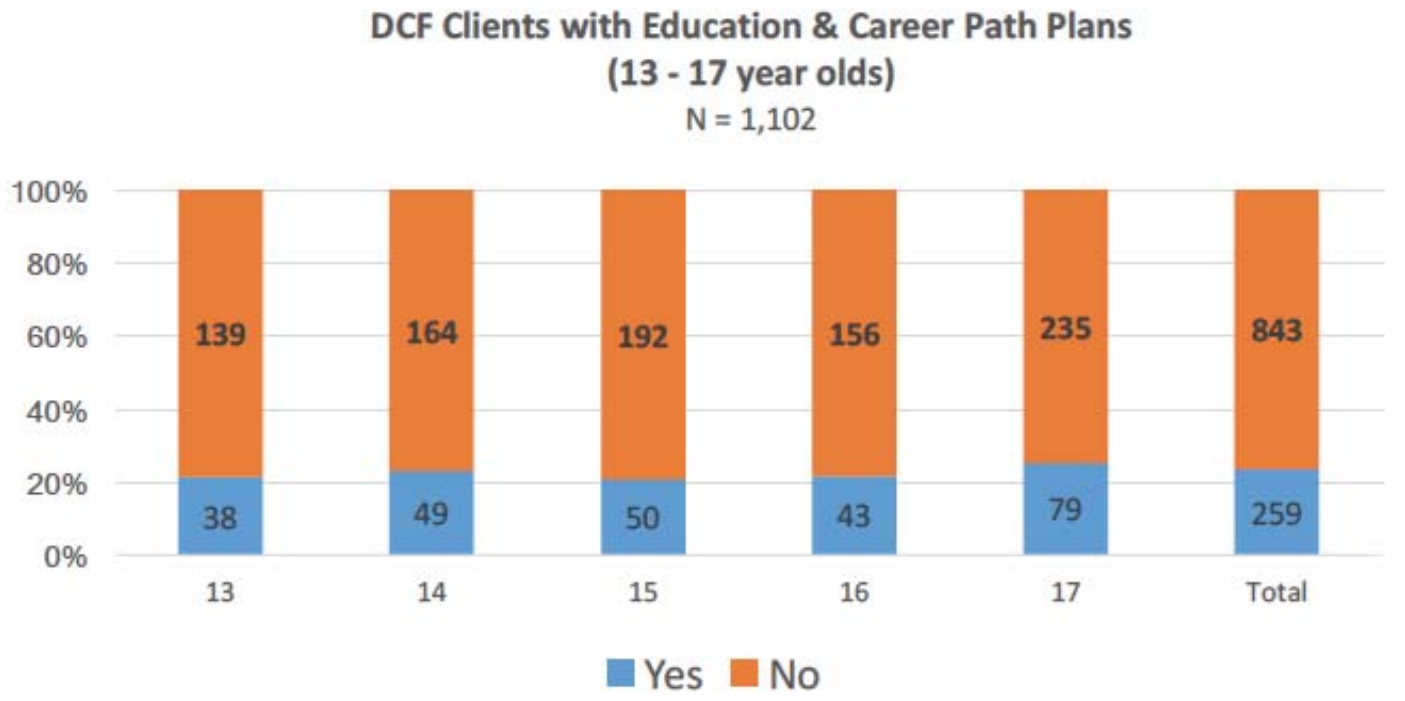
In spite of significant challenges, youth in the foster care system demonstrate extraordinary courage, determination and resilience. It is important to provide these youth, and the adults who support them, with the resources and assistance needed to achieve stability and independence.

Early intervention and access to some existing educational programs can help a caregiver, case manager, mentor, or Guardian ad Litem volunteer navigate through the education system and support foster youth struggling in school. On the other end of the educational continuum, post-secondary institutions, it is vital that adults emerging from care receive ongoing support on campus and from the community, to compliment the generous financial provisions made by the state to fund educational and living expenses for this population. This support also is vital as a response to the State Legislature's innovative mandate requiring that the State University System (SUS) and the Florida College System (FCS) establish dedicated campus coaches for students eligible for the tuition and fee exemption as outlined in s.1009.25 (Florida Statutes).

The State contends, and THE COUNCIL concurs, that a system of campus-based support programs can help ensure that more young adults from foster care can avoid the "myriad negative long-term outcomes" that continue to plague the majority of these resilient yet troubled young adults.

DATA

During the past decade, the State of Florida has consistently made efforts to improve the collection, processing, and dissemination of data on the educational progress of young people in its care. Two of the key data collection methods used to collect data on the education status of this population in Florida are the My Services Survey (administered to 13 – 17 year olds) and the NYTD Florida Survey (administered to 18-22 year olds). Two vital pieces of information from this data are related to the action steps THE COUNCIL took during the year in that they indicate ongoing educational challenges related to young people in care.



For instance, data from the 2015 My Services Survey indicates that only 34% of the 235 seventeen year olds in state custody have an education and career path plan, which is a key component of preparing young adults for their future. Furthermore, data from the 2015 NYTD Florida indicates that of the 1,424 transitioning adults surveyed, only 60% had earned a high school diploma or GED. More troubling is the fact that only 6% had earned a vocational certificate or vocational license, and the same percent had earned an associates degree. These results are in response to the question "What is the highest educational degree or certification that you have received?"

Throughout the state, a key set of data that is missing relates to information on the educational progress of young adults attending public post-secondary institutions. Understanding this gap, the Florida Legislature has mandated that the FCS and the SUS develop reports for DCF on the status and progress of young adults from foster care who are receiving the state education fee exemption. To support this requirement and to offer the opportunity for strong collaboration, DCF has released an Request For Proposal that includes funding for research on youth from foster care attending post-secondary institutions in the State.

RECOMMENDATIONS

THE COUNCIL recognizes that there are existing support systems within school districts and, to a lesser degree, Florida's public colleges and universities, to assist foster youth and the adults who support them. THE COUNCIL therefore recommends that:

1. DCF requires case managers to be knowledgeable about the Multi-Tiered System of Supports and how to work with school personnel to plan interventions to support foster youth struggling in school. DCF should require case managers, foster parents and group home managers to complete an online training on the Multi-Tiered System of Supports developed in collaboration with Department of Education's PS/RtI Project, THE COUNCIL and DCF Staff.

2. DCF should require case managers through in-service training to be knowledgeable of online resources for education and career planning that exist to help guide older foster youth in the direction of attaining educational goals. Free resources exist in the state of Florida such as, My Career Shines Career Navigator system, that help foster youth access and apply their career plan consistently for academic success and independent living.

3. DCF should pursue its plan to provide funding to a qualified organization that will coordinate, develop, and maintain a network of post-secondary campus-based support initiatives across the Florida public college and university systems.

4. DCF should continue working closely with state level leaders at DOE, the State University System, and the Florida College System, to support the work of what will be a fledgling, mostly volunteer-driven statewide initiative related to campus based support initiatives across Florida's public college and university systems.

Meet Janice, James, and Chelsea, advocating to Sen. Nancy Detert on behalf of youth in Foster Care while serving as representatives from Florida Youth SHINE.

Housing

KEY QUESTION

Now that older foster youth are able to remain in care beyond 18 years old, what types of housing options exist for young adults to best support them, and how is this tracked?

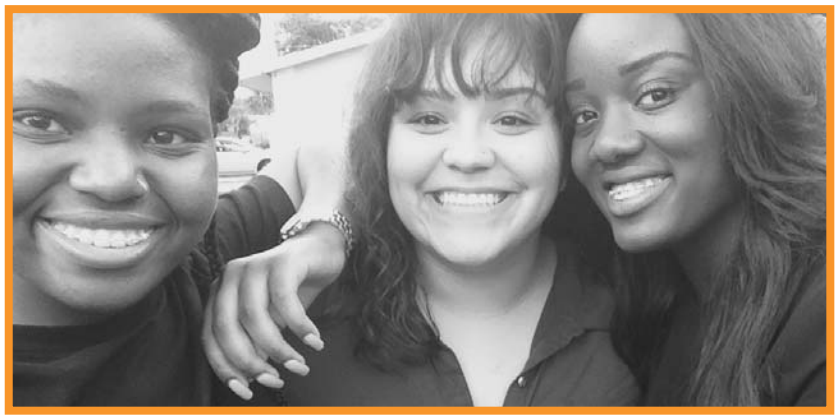
STEPS TAKEN BY COUNCIL

Throughout the 2016 calendar year, THE COUNCIL met to explore options that exist throughout the state since new legislation was enacted to support older foster youth post age 18. THE COUNCIL was driven by a concern that extending care without the proper supports in place was merely moving the challenges older foster youth faced at the age of 18 to the age of 21. Connection to permanent supportive adults appeared to be part of the housing formula for successfully integrating youth from child welfare to adulthood and the following methods were explored: ***Supportive Housing Programs, Housing Coordination***, ***Low Income Options*** and ***Host Families.***

Meet Diane Schofield and Staff, from Hands of Mercy Everywhere Maternity Group Home for young mothers.

Meet Francis, college graduate with support from his housing program.

Meet Sandina, Georgina, and Melissa, who all met while living at Vita Nova Village apartments in West Palm Beach.



FINDINGS

SUPPORTIVE HOUSING PROGRAMS:

Fortunately, some counties in Florida have supportive housing programs for young people from foster care. These programs are typically apartments or living arrangements that are governed by independent non-profits that allow youth 18+ from foster care to live, since many of these young people are unable to safely return home to their parents.

While living in these housing programs, youth obtain daily support, guidance, and mentorship about life skills leading to self-sufficiency. Although there is no uniformity in the delivery of life skills material from program to program, these environments are able to take advantage of real time teaching scenarios so that residents can learn cooking, cleaning, and critical thinking skills in a practice environment where it is safe to learn from their mistakes.

Models for transitional housing are typically cheaper than allowing a youth to remain in group care, or rent on their own, and come with 24-hour support. The program fees from those presented to the Council averaged $1100/month with electric, internet and support services included. According to a 2014 OPPAGA study, in the 2013-2014 fiscal year, the per diem rate for the shift-care group home model averaged $124 per day, or $3720 per month. The cost of group home care in Florida for the 2013-14 fiscal year was $81.7 million. Based on the average cost per day at a group home this assumes 1800 youth over the course of a year. Transitional housing in comparison would have cost approximately $24.8 million per year.

Given that many of these programs offer help with mental health, trauma counseling and daily support this price was affordable against the costs some CBCs pay related to early termination of leases, resetting security deposits with community landlords, or remaining in group homes.

Finally, youth living in these programs typically appreciate living in a community of peers with shared experiences. It is not uncommon to see camaraderie within these housing programs, adding value to additional peer to peer support young people need to thrive on their own.

HOUSING COORDINATION:

Since the implementation of extended foster care, one of the major challenges around the state was finding supportive housing options when group homes, and foster homes were not an option. In addition to the expense, group care providers and foster homes had to negotiate the logistics of having youth over and under 18 living in the same communal space. This often leads to youth having to remain in extended foster care in a setting different than what was intended in the law such as having to move out of their placement on their 18th birthday to an apartment.

To help address these challenges, housing coordination has been explored in certain areas of the state to allow for certain independent living programs to refer older clients to a person who specializes in the housing options that exist in their area. For some areas in the state, housing coordinators exist to:

- Assist child welfare case managers with housing options when a youth is eligible for extended foster care.
- Serve as the entry point for all older independent living youth to enter to get help with housing.
- Partner with other housing coordinators in other systems to prevent clients from moving between homeless services to child welfare services and vice versa.

LOW INCOME HOUSING:

In some areas housing coordinators were also used to connect IL youth with local low income housing providers to allow IL youth formerly in care to begin the process of accessing low cost rental options. When units are made available through low income initiatives youth are connected to these units through the housing coordinator. This can result in a youth paying hundreds of dollars less for rentals each month in areas that are safe and affordable, so that other income, or scholarships can be used for daily living needs.

Housing coordinators can also serve as single points of contact for landlords who oversee the units designated for low income renters. This can help prevent evictions and problems between the tenant and landlord. Youth must be willing to meet with the housing coordinator to review lease requirements and correct behaviors that would result in an eviction.

There are steps required through the Housing Authorities in each area to become the single point of contact, but once this is established, older youth have additional options for affordable places to live in their area.

HOST FAMILIES:

Finally, housing coordinators and certain independent living programs in the state have taken on the role of recruitment of host families for older foster youth. Since there are no guidelines that host families have to be licensed placements prior to accepting an older foster youth (18+) this allows for quicker recruitment of new homes and placements for young adults. The challenge is to properly screen and train host families about the expectations and the challenges related to supporting older foster youth.

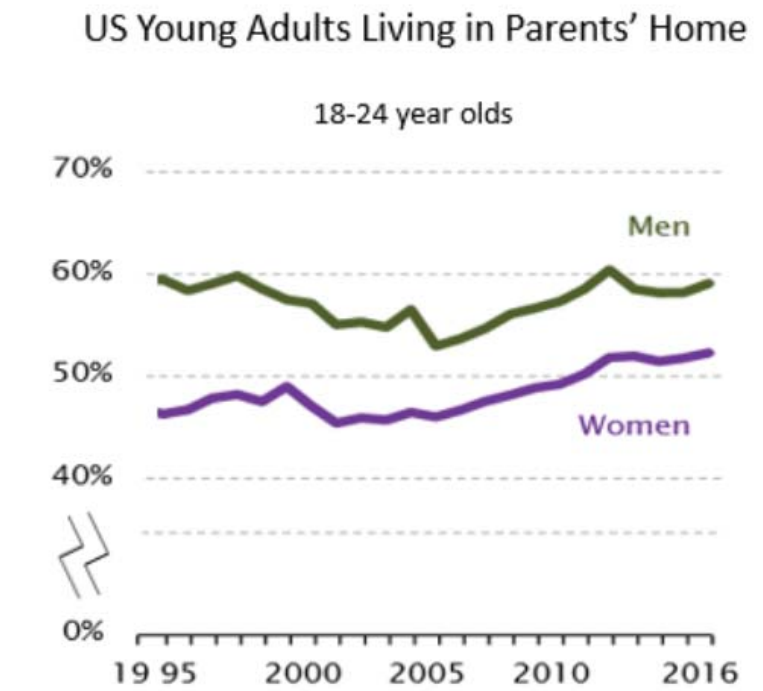
Many counties have successfully recruited host families to help older foster youth with short and long-term goals after turning 18 years old. Through support of host families, many youth are able to graduate high school, complete college, begin employment, and get a driver's license all while being in stable housing.

Older foster youth learning how to cook at the Destiny House, located in Daytona.

Meet Anna, about to finish high school and travel to England along a student education program.

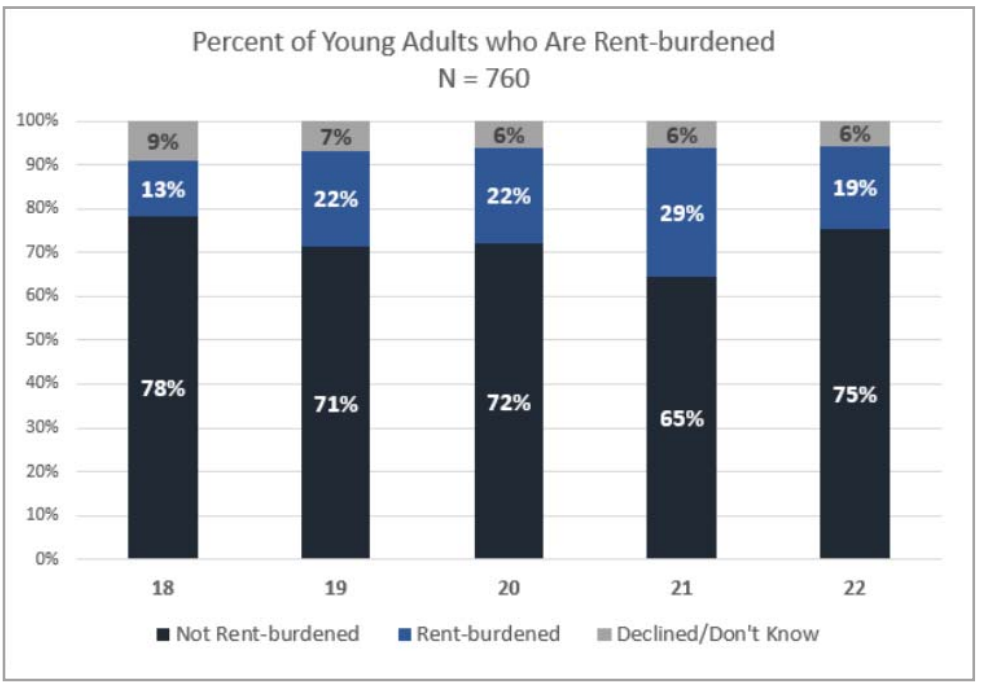
DATA

Throughout the nation, high percentages of young people between the ages of 18 and 24 live with their parents. The US Census Bureau reports that more than 50% of young women, and nearly 60% of young men in America, still live at home (see chart below). For young adults who are emancipated from foster care, there is usually still no viable "parent" home available to them. When there is, that option is usually not possible, desirable or safe.



Source: US Census bureau

So many young Americans live at home because rent is so high in most parts of the nation. In fact, the US Census Bureau reports that of the young people who are renting are considered "rent burdened"—meaning housing eats up around a third or more of their income.



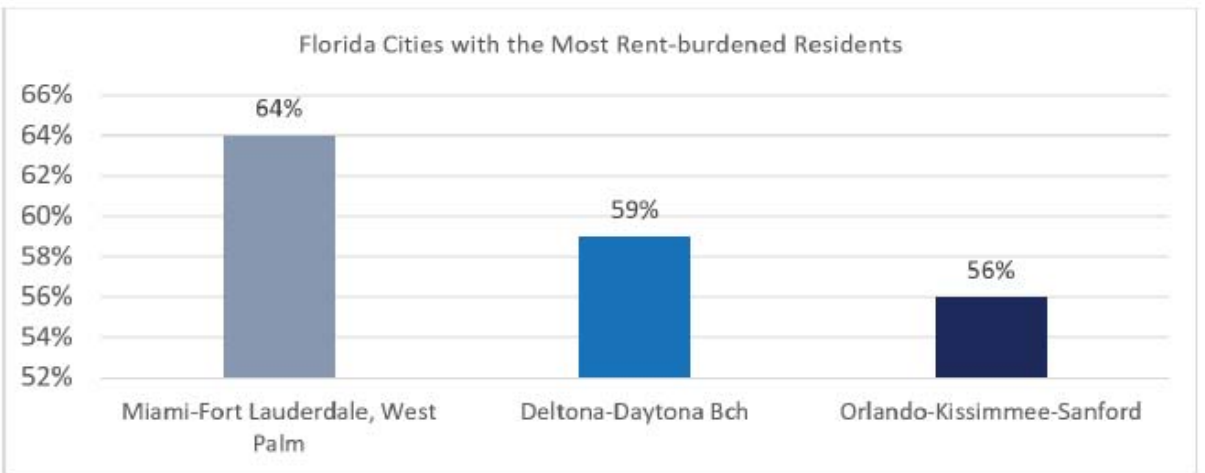
Rent burdened can also mean that after paying rent, little is left over for other living essentials, which is how the question was framed for Florida National Youth in Transition Database (NYTD) respondents. Florida DCF implemented an expanded version of NYTD to be used on an annual basis to survey our young people ages 18-22 who have aged out the state foster care system. The chart below is based on the responses of 760 young adults from care who answered this survey question.

After paying for your housing, do you still have enough for your other living expenses such as food, transportation, or utilities?						
	18	19	20	21	22	Total
Yes	43	75	121	106	202	547
No	7	23	37	48	51	166
Declined	1	4	4	4	5	18
Do not know	4	3	6	6	10	29
Total	55	105	168	164	268	760
Percentage Yes (Not Including "Declined/Do Not Know")	86%	77%	77%	69%	80%	77%

Source: 2016 Florida NYTD Survey

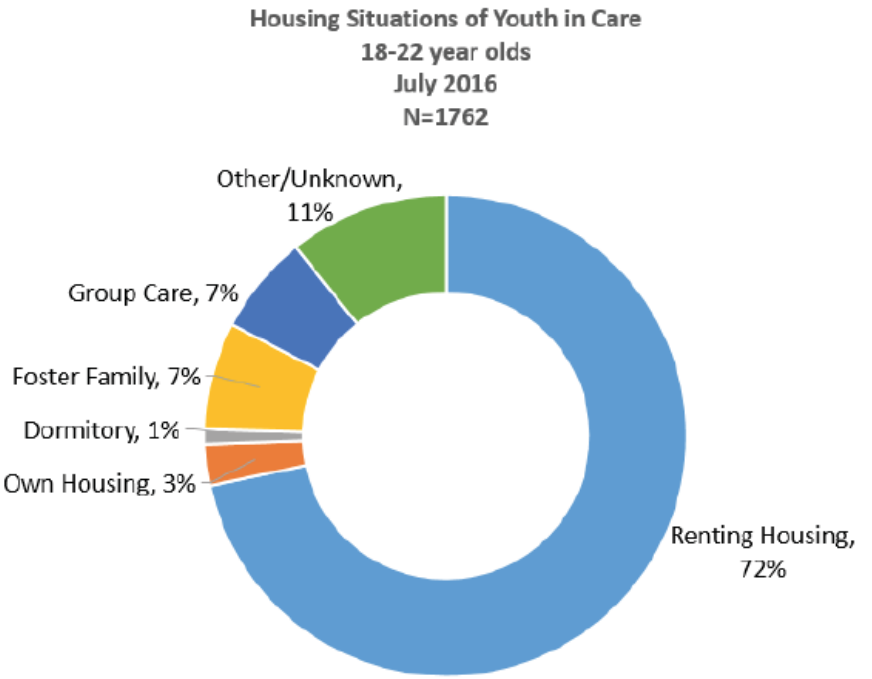
Of the 100 Metropolitan Statistical Areas (MSA) in the United States with the most renters, Miami-Fort Lauderdale-West Palm Beach took the lead over the top 20 cities by a wide margin. Almost 64% of its renters — the vast majority of whom earn less than $35,000 per year — are rent-burdened.

The chart below shows the percent of rent-burdened residents in three Florida MSAs, areas that also have large numbers of former foster youth struggling to establish themselves as independent adults. These areas are the Miami-Fort Lauderdale-West Palm Beach MSA, the Deltona-Daytona Beach-Ormond Beach MSA, and the Orlando-Kissimmee-Sanford MSA. In almost every case, the majority of the rent-burdened renters are making less than $20,000, which characterizes the population on which ILSAC focuses.



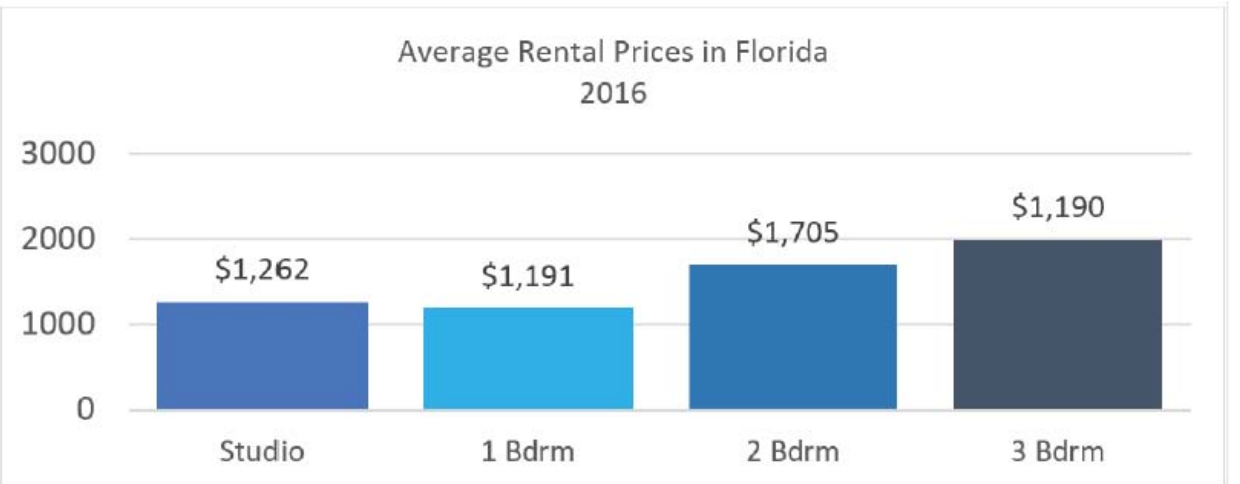
Source: US Census Bureau, 2016

Data regarding older foster youth and their living arrangements is tracked by entering the living arrangements for each youth into the DCF Database known as Florida Safe Family Network (FSFN). Information from FSFN yields statewide data that can be compiled in a number of ways. The chart below, based on FSFN data, indicates that 72% of Florida's young adult population transitioning from foster care rent housing.



Source: Florida Department of Children and Families FSFN, 2016

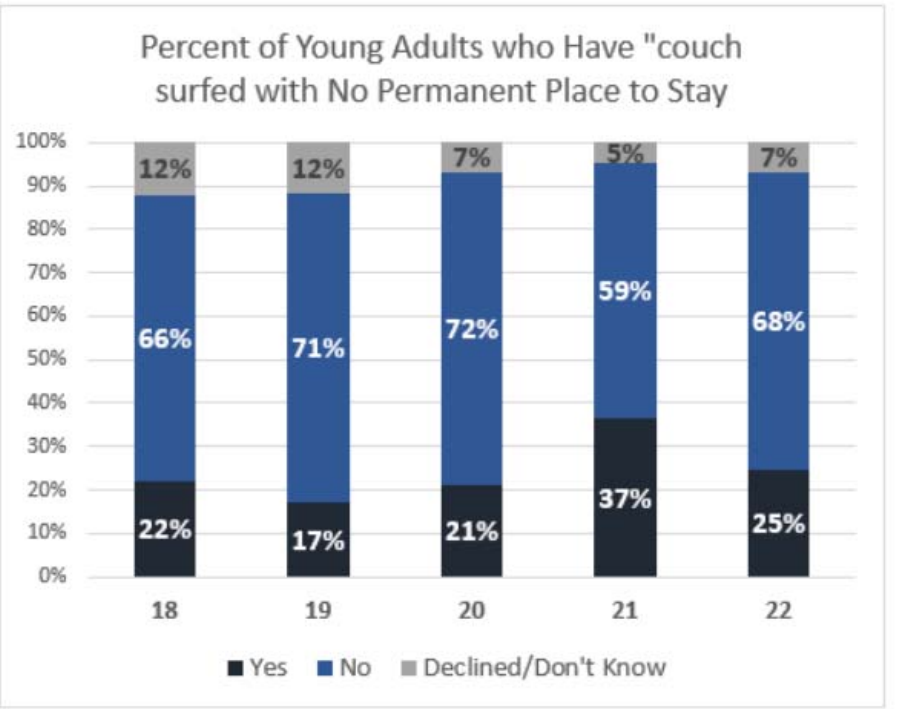
It stands to reason that these young adults are also rent burdened, especially since the majority of them live in Florida's metropolitan areas, where rental prices average $1,262 for studio apartments, and $1,191 for 1 bedroom apartments (see chart below).



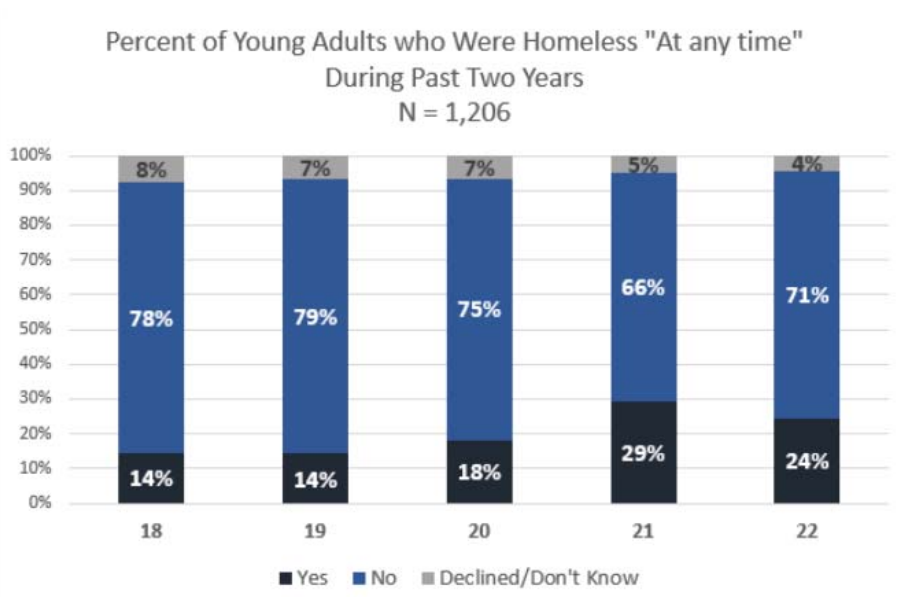
Source: US Census Bureau, 2016

The Florida NYTD survey, which gathers self-reported data directly from young adults each year, provides information on homelessness among this population. Despite this data there appears to be a lack of tracking, reporting or monitoring for older foster youth and homelessness by DCF.

The 2016 Florida NYTD indicates that homelessness is a recurring theme, and as evidenced by the two charts below where a number of respondents indicated they did not have a place of their own to stay, or experienced homelessness in the past 24 months.



Source: 2016 Florida NYTD Survey



Some members of the COUNCIL have questioned how respondents in foster care can also report that they are homeless. This leads to an overall concern that the numbers that are collected by DCF and FSFN do not indicate the total number of eligible youth able to receive IL services. FSFN only tracks youth actively receiving a service or a payment. This will leave out a portion of the total population still eligible, yet possibly disconnected from resources.

The direct answer to this question, after exploration the subject further, is that there is not enough information requested by or given to THE COUNCIL to tell how many youth are eligible in addition to the youth accessing services. In short, THE COUNCIL has not been given clear data that tracks the total population of youth known to DCF ages 18 to 22. This will be an area for future consideration as THE COUNCIL continues to examine housing options and the ramifications of lack of housing in future meetings.

RECOMMENDATIONS

After a review of the information related to how the new law has been implemented, and the housing options that exist, THE COUNCIL is making the following recommendations to DCF:

1. There is a lack of data indicating the degree of homelessness among foster youth from within DCF. THE COUNCIL recommends that DCF should improve the tracking and monitoring of data to accurately capture how many young adults formerly from foster care are currently homeless.

2. Given the presentation of practices used in Broward County, Palm Beach County and Jacksonville related to Supportive Housing Programs, Housing Coordination and Host Families, DCF should incorporate training of these models as a portion of the statewide Independent Living quarterly meetings and phone calls. Training can include exploring how these models are implemented, outcomes relative to placement longevity and permanent connections of IL youth to supportive adults.

3. DCF should create a plan using the appropriate personnel within DCF to bring uniformity to implementing Aftercare Services, to ensure that community based care agencies are held accountable for providing services and financial assistance to young adults who are eligible in order to avoid homelessness. This plan can be presented to THE COUNCIL during the 2017 ILSAC meeting schedule.

4. THE COUNCIL recommends DCF improve tracking and monitoring of data to accurately capture how many young adults formerly from foster care are accessing supportive housing options/programs post age 18. The DCF database (called Florida Safe Family Network) could begin with providing better clarification to case managers for older foster youth about the types of housing older foster youth are accessing.

Teen Parenting

KEY QUESTION

How can we better support teen parents in foster care and those aging out, in the areas specific to quality housing and daycare?

STEPS TAKEN BY COUNCIL

Challenges related to independent living services specific to older foster youth who are teen parents has been a concern for THE COUNCIL in previous reports. In fact, since 2013 THE COUNCIL has made nearly 20 recommendations about how to improve these services older foster youth.

In 2016 THE COUNCIL decided to begin with a review of those recommendations and revisit those currently most pressing for older foster youth. THE COUNCIL took the following steps to get updated information.

THE COUNCIL received a detailed presentation and had discussions in line with the 2015 Florida State University (FSU) Institute for Child Welfare Report which states that young parents aging out of foster care face known economic, educational, and housing obstacles that have the potential to limit their capacity to meet their children's needs. Additionally, experiences of trauma can impact the ability of parents aging out to provide a safe and nurturing home and to meet their children's needs. Increasing a parents' capacity to provide for their children's needs warrants increased attention for this unique population of Florida's young parents who turn 18 in foster care.

FINDINGS

Additional funding is required through foster care dollars, prevention dollars, and/or other funding sources to specifically support Extended Foster Care populations of pregnant and parenting youth and their babies. To most effectively serve this population, funding should be provided to allow the parent and child(ren) to remain in or relocate to a quality parenting driven program at age 18 with the option to remain until they have received specialized services and attained the necessary skills a young parent and child desperately need. Findings from previous Council reports and current research indicates:

- F.S. 39.6241(4)(a) "A young adult may continue to reside with the same licensed foster family or group care provider with whom she/he was residing at the time she/he reached the age of 18 years old."
- Foster homes for teen parents should utilize a co-parenting model with evidence based parenting programs.

- There is a need for maternity homes that offer specialized transition services such as navigating ELC, child/mother Medicaid eligibility, WIC, ACCESS services, baby court, children's mental health services, evidence-based parenting programs, and staff trained specifically to care for the parenting population and trauma-informed care.
- There is a need for human trafficking residential placements that offer parenting youth that have been sex trafficked and are at risk, the opportunity to be in a safe environment while learning how to successfully parent.
- Safety risk of transitioning an ill-equipped young parent, with minimal parenting and daily living skills into an unsupervised and unsupported living environment presents too high a risk for the mother and child(ren). This can prevent babies of young adults aging out of foster care from experiencing maltreatment. Some of the young parent risk factors can be attributed to their developmental limits, care giving inexperience, lack of parental example, as well as limited child care resources.
- Young parents need help understanding how their past trauma experiences impact their emotions and ability to successfully parent. They also need help understanding how they can prevent their child from going into foster care.

Barriers should be removed that could prevent young parents from residing in a quality parenting environment as they transition from foster care. Removing these barriers could prevent intergenerational transmission of child maltreatment through multiple generations. Several opportunities to intervene and to change a dangerous trajectory, such as:

- Relocate youth when in the best interest of the teen mother or baby. Moving and/or changing schools out of county may be the best solution to have a fresh start and get young mothers away from possible gangs, sex trafficking, or other bad influences.
- Provide opportunities for parenting in protective, supportive environments. As a teen mother feels safe and protected she will protect her child.
- Focus on the ongoing needs of both parent and baby. Their needs are constantly changing and require a much higher level of supervision and support.
- Young parents who have previously lost custody of their children need assistance navigating Baby Court to help prevent their baby from coming back into the DCF system.
- Babies of teen mothers who do not attend a quality daycare are at a great risk of abuse, neglect and abandonment.

A young mother and her child from Hands of Mercy Everywhere Maternity Group Home.

DATA

To truly understand and serve the needs of this specialized population, COUNCIL members suggest in conjunction with the FSU Institute of Child Welfare that the following information be collected and analyzed:

- Data on the number of youth who are in the child welfare system who are pregnant, have given birth, or fathered a child.

- Data on the number of young women and men who have recently aged out of the child welfare system who have given birth, are about to give birth or fathered a child.

- Data on the number of children who are in the physical custody of their young parent who is in foster care or recently aged out.

- Data on the number of these children who are in DCF custody but live in the same home as their young parent who is in foster care or recently aged out.

- Data on the number of these children who live separately from their young parents who is in foster care or recently aged out.

- Data on the number of young parents in foster care or recently aged out that have an open DCF case but are working a case plan in hopes of reunification.

- Data on the number of these children whose young parents' rights have been terminated.

The most recent data collected about teen parents and foster care come from many sources. Below is the data collected from various reports from 2016.

- Connected By 25 recent report- Almost 50% of DCF youth aging out of foster care will experience homelessness after they age out.
- Nearly half the children in residential group care have behavior problems, and after their stay they tend to need more time in foster care.
- Studies of young parents who were previously in foster care found that approximately 39% had been investigated for child abuse or neglect, with 11% of the cases resulting in the child being removed from their teen parent's custody.
- The NLSAAH, a nationally representative sample of adolescents, found that 50% of female youth still in care or recently aged out become pregnant by age 19 compared to approximately 20% of same-aged females in the general population.

Data continued...

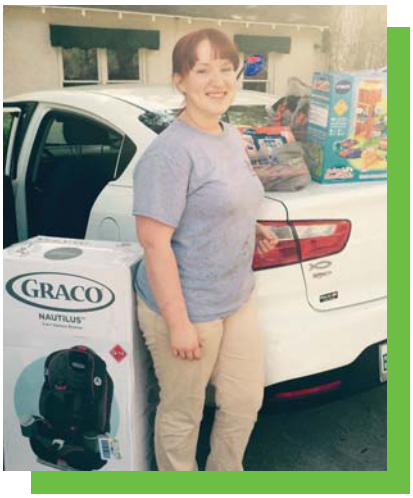
- 39% of young mothers are more likely to have another child before 20.
- Casey Foundation stated that teen parents who opt into Extended Foster Care are less likely to be homeless, are more likely to attend school, and have a higher overall earning potential.
- Princeton University found that public subsidies support child care for only 15% of eligible families.

RECOMMENDATIONS

1. THE COUNCIL recommends that increased funding be provided to support specialized services, training, and the level of care needed so that youth in Extended Foster Care who are pregnant and parenting can remain in or relocate to quality parenting-driven programs. This funding is imperative to ensure that the youth have access to programs that can enable them to develop the skills they need to successfully parent. The additional funding can come from additional foster care dollars, prevention dollars, and/or other funding sources.

2. THE COUNCIL recommended that as the pregnant or parenting youth transitions to age 18, that the courts ensure "quality" of the case plan by providing follow-up. Since there is currently no requirement for follow-up, THE COUNCIL is recommending a legislative change that at **a maximum of 30 days, DCF and the courts ensure that the expected case plan requirements related to parenting are met.** This follow-up must take place to ensure that there is no disruption or discontinuation of services after the youth turns 18 years of age. THE COUNCIL is strongly recommending that this language be submitted in DCF's proposed legislation for 2017.

3. THE COUNCIL recommends that DCF provide parenting youth with a Daycare Free Fast Pass. This Fast Pass would provide young parents with absolutely free, flexible, quality daycare that is easily accessible and would remove financial barriers that may prevent a child from attending daycare; therefore, reducing their risk of being abused, neglected and/or abandoned by their young parent.



Meet Jesse, Kids Central Inc., she is completing her final semester of college, in her final year of the PESS Program at the end of the Fall 2016.

Employment

KEY QUESTION

1. What type of partnerships and/or data sharing agreements are needed to ensure employment data is collected and tracked by the Florida Department of Children and Families for youth who are in dependency care?

2. What type of FSFN enhancements and program policies need to be adopted by the Department of Children and Families and the contract providers to ensure employment data is consistently collected, evaluated, shared, and leveraged to improve the outcomes for youth who are in dependency care?

STEPS TAKEN BY COUNCIL

During the 2015 year, ILSAC formed an Employment workgroup that met to discuss the issues that impact employment for youth in care. The workgroup initiated a "data match" project in partnership with the Florida Department of Economic Opportunity. The goal of the project was to answer the following question: "Of the youth who were in care in 2015, how many were employed (as reported by the Florida Department of Revenue – Employer files)?

Working with DCF IL staff, the DEO staff matched the youth's records with the DOR Wage file that reflected the number of youth who were employed. This project demonstrated that DCF and DEO/DOR can share data in a format that can provide the employment status of youth who are in care. The results of the Employment workgroup's project was shared with the full ILSAC during a meeting. Additionally, throughout the year, the ILSAC received employment-related information and updates during the meetings as well as explored strategies to improve local partnerships with the CareerSource Florida network, Vocational Rehabilitation and other employment program partners that serve youth in dependency care.

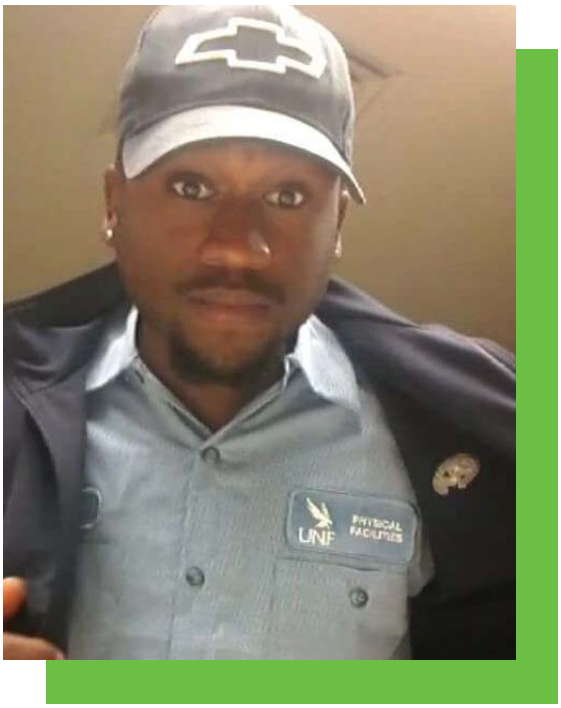
Meet Deondre, aspiring to be a future chef by completing a culinary course at the Florida Sheriff's Youth Ranch.

FINDINGS

DCF is responsible for ensuring that older youth in the Independent Living program receive the services and supports needed to successfully transition to adulthood and achieve economic self-sufficiency. Youth who are gainfully employed and who earn a living wage, are on the path to becoming self-sufficient and living as a productive member of society.

Currently, employment data for youth who are in care, is not consistently entered in to DCF's database (FSFN). In Florida, there are several different groups/entities that collect employment data about youth in foster care and the data is collected in different ways. For example, the Department of Children and Families (DCF) receives employment information from lead agencies and records the information in FSFN. The Florida Department of Revenue (DOR) collects the information from employer tax records. Connected by 25 collects data via surveys of foster youth in care.
Additionally, there is currently no process or official data sharing agreements in place at DCF that would:

- Create a common data source and time schedule for producing reports related to employment for youth in care
- Allow the identification and tracking of the employment status of youth in care on a consistent basis
- Allow accurate reports to be generated from FSFN that reflect the employment status of youth in care
- Allow the input/transfer of employment data in to FSFN from other program partners.



IL youth are capable of amazing things, this young man secures employment at the University of North Florida.

DATA

The data sources used this year related to employment included data from the Florida Department of Children and Families, the Florida Department of Revenue, the Florida Department of Economic Opportunity (DEO) and the Community-Based Care entities from across the state.

Below is information from DEO related to the numbers of older foster youth who are employed by CBC in Florida.

RECOMMENDATIONS

To continue advancing previous COUNCIL recommendations related to employment, THE COUNCIL recommends the following:

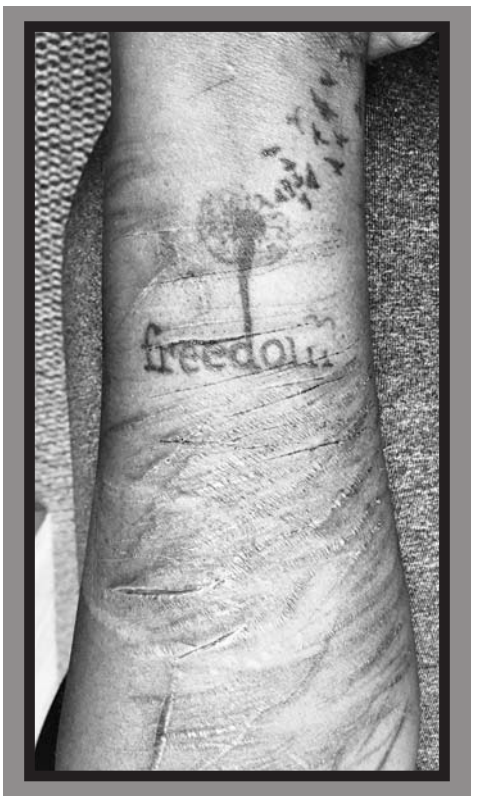
1. DCF should develop and adopt operating procedures, definition of common terms and expectations that emphasize employment as a viable option for youth in out of home care who are preparing to transition to adulthood.

2. DCF should enter into a Data Sharing Agreement with DEO and DOR to receive employment status data for youth in care and provide quarterly updates to THE COUNCIL.

3. DCF should evaluate the current capacity of FSFN, implement necessary system enhancements and program policies to record and track the employment status of all youth who are in care at the state level. If system enhancements are required to collect the data, DCF should approve such enhancements and update the terms of the CBC's contracts to require that data related to employment be entered in FSFN.

4. Youth employment should be included on DCF scorecard as a key component of the system of care. DCF should require the collection and use of employment related data to promote normalcy for youth in dependency care.

5. DCF should revise its Quality Assurance system to evaluate the collection and management of data related to IL youth who are employed. Additionally, IL youth employment should be included in QA reports.



The Independent Living Services Advisory Council recognizes the scars some of our youth endure and endeavor to prevent future ones.

Reducing the Numbers of Dependent Children Involved in Delinquency Court

KEY QUESTION

1. Why are DCF children significantly different in both issuance and successful completion rates?
2. Once the reason is identified, how can DCF and its partners work within each county to eradicate the statistical difference?

STEPS TAKEN BY COUNCIL

ILSAC has reviewed information presented by members Deborah Schroth (DCF/CLS) and Jeannie Becker-Powell (DJJ) to understand the importance of civil citations and to learn and question the use and success of civil citations for DCF children.

Individual members have attended presentations on this issue at the FCC conference in July 2016 and the DCF Summit in September 2016. These presentations were by Deborah Schroth and Theda Roberts, Civil Citation Coordinator, Florida Dept. of Juvenile Justice.

FINDINGS

Data from the Florida Department of Juvenile Justice (DJJ) and the Florida Department of Children and Families (DCF) show that there are two problems with civil citations for children in out-of-home care: DCF children who are eligible for civil citation in lieu of arrest have an issuance rate that is statistically significantly lower than the rate for their non-DCF community peers; and when DCF children are actually issued civil citations, their rate of successful completion, meaning that there are no further law enforcement/ DJJ actions and there is never a recorded arrest, is significantly statistically lower than the successful completion rate of their non-DCF peers.

The Florida Juvenile Civil Citation Initiative provides law enforcement an alternative to arrest for youth under the age of 18 who commit non-serious misdemeanor offense. Civil citations provide accountability by the youth for the offense by determining interventions and consequences based on an assessment of the youth's risk to reoffend and sanctions are assigned.

Civil citation helps youth totally avoid a criminal arrest and history record that can impede future opportunities in the military, secondary and post-secondary academic or vocational education, and in housing. Youth who successfully complete civil citation requirements have proven to be less likely to have further involvement with the juvenile justice system. This can mean that a youth who is chastised for non-serious bad behavior through a civil citation does not go on to later commit any felonies.

Civil citation is uniquely different from post-arrest diversionary programs. A successfully completed post-arrest program results in the dropping of the charges, but the fact of the arrest remains on the youth's record. A successfully completed civil citation program results in no juvenile justice record, as the youth was never formally arrested. Further, because a youth in Florida may receive up to three civil citations in their minority for qualifying offenses, provided the youth has never been formally arrested, if a youth commits a non-serious offense today and is cited, if the youth makes another mistake during childhood, the youth will not necessarily be subject to arrest. For example: youth is involved in a minor "disrupting a school function" offense at the age of 12. If the youth successfully completes a civil citation, there is no arrest. If, at the age of 17, the youth makes another mistake and pickpockets a small item, the youth may again receive a civil citation. But if that youth was arrested at the age of 12, then the minor mistake at the age of 17 must result in an arrest for this very minor offense.

DATA

Unfortunately, the DJJ-DCF dually served dashboard does not contain civil citation information. That information is available from DJJ, but has not yet been made public via its website.

DJJ has provided the following information:

For calendar year 2014, the civil citation issuance rate for all eligible youth statewide was 41%. Contrast: the issuance rate for DCF youth in out-of-home care was only 32%, a 9% difference to the detriment of our youth.

For fiscal year 2014 – 2015, the civil citation completion rate for all youth who were issued civil citations was 80%. Contrast: the successful completion rate in that same time period for DCF youth was only 66%, a 14% difference.

General data for crossover youth:
Online Data for Crossover youth and Dually Served Youth
Presentation on Civil Citation presented to ILSAC 2016
(Click to links to learn more)

RECOMMENDATIONS

DCF should task a staff person with accomplishing the following recommendations. If there is a Restorative Justice staff member, THE COUNCIL suggests that is the most logical person to be tasked, as the civil citation program is an important component of restorative justice, especially in our schools, which account for a significant percentage of DJJ involvement by our youth.

1. It is necessary to determine why DCF youth have a lower issuance rate of civil citations by working with local law enforcement agencies (LEA) to dispel any myths they may have about children in foster care, and to resolve any real issues they may have with the child welfare system. For example, it may be that LEA do not understand who to contact; or may believe that a foster home will not support a youth in completing citation sanctions. If the latter is true, then DCF should consider mandating support for youth with DJJ involvement, including civil citation sanctions, in its licensing rules and contracts.

2. For those counties which simply do not offer civil citations at all, local CBCs, partnering with DCF and identified local youth advocacy groups, should explore with LEA why this is, and attempt to convince LEA of the benefits of this program.

3. It is also necessary to determine why DCF youth who are issued a civil citation have a lower successful completion rate, and then explore how to resolve this. Some conjectures: the foster parent or group home may not have the ability (or desire) to transport a youth to required sanctions; there may be a lack of communication when a youth with a sanction is transferred to another county for residence. DCF should include civil citation data elements in FSFN to ensure the necessary communication. DCF should also work with the CBCs and CMOs to ensure adequate training of the civil citation program and its requirements and benefits for our youth, and to determine how to better support our youth who are issued citations in successfully completing their sanctions and responsibilities.

4. DCF should work with DJJ at the state level to ensure there is timely sharing of civil citation cross-over data at both the state and local levels.

10 years

2016 Independent Living Services

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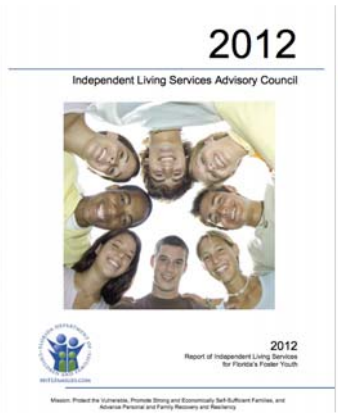

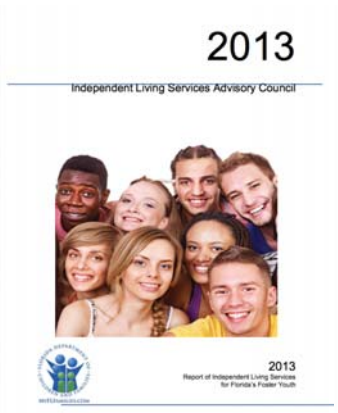

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Department of Children and Families
Office of Child Welfare
Response to the
Independent Living Services Advisory Council
2016 Annual Report

December 31, 2016

Mike Carroll
Secretary

Rick Scott
Governor

ILSAC RECOMMENDATIONS ON EDUCATION

THE COUNCIL recognizes that there are existing support systems within school districts and, to a lesser degree, Florida's public colleges and universities, to assist foster youth and the adults who support them. THE COUNCIL, therefore, recommends that:

1. DCF require case managers to be knowledgeable about the Multi-Tiered System of Supports and how to work with school personnel to plan interventions to support foster youth struggling in school. DCF should require case managers, foster parents and group home managers to complete an online training on the Multi-Tiered System of Supports developed in collaboration with Department of Education's PS/RtI Project, THE COUNCIL and DCF Staff.

2. DCF should require case managers through in-service training to be knowledgeable of online resources for education and career planning that exist to help guide older foster youth in the direction of attaining educational goals. Free resources exist in the state of Florida, such as My Career Shines Career Navigator system, that help foster youth access and apply their career plan consistently for academic success and independent living.

3. DCF should pursue its plan to provide funding to a qualified organization that will coordinate, develop, and maintain a network of postsecondary campus-based support initiatives across the Florida public college and university systems.

4. DCF should continue working closely with state level leaders at DOE, the State University System, and the Florida College System, to support the work of what will be a fledgling, mostly volunteer-driven statewide initiative related to campus-based support initiatives across Florida's public college and university systems.

DEPARTMENT RESPONSE

Improving educational (academic or vocational) attainment is one of six outcome areas tracked by the Administration for Children and Families (ACF) through the National Youth in Transition Database (NYTD). The Department complies with all federal regulations related to assistance to former foster care youth and transmits data to NYTD from the Florida Safe Families Network (FSFN), the statewide automated child welfare information system.

The Department also recognizes that there are various supportive structures, including the Multi-Tiered System of Supports (MTSS), designed to assist youth with achieving their educational goals. Several areas in Florida law cite requirements related to continued education for dependent youth. Section 409.145, Florida Statutes (F.S.), includes roles and responsibilities of caregivers, the Department, Community-Based Care Lead Agencies (CBCs), and other agency staff on how to support youths' educational success. Section 39.0016, F.S., addresses interagency agreements between school districts, the Department, CBCs, and other agencies, including the coordination of relevant training. Section 409.1452, F.S., mandates collaboration with the Board of Governors, Florida College System, and Department of Education to assist children and young adults who have been or are in foster care.

The Department supports case managers, independent living specialists, foster parents, and group home managers in acquiring relevant training or skills available to further support the educational needs of the youth in the child welfare system. The Department will collaborate with Department of Education (DOE) and CBC Lead Agencies' training coordinators to ensure adequate training materials are available.

In November 2016, the Department advertised a request for proposals to procure a provider to coordinate, develop, and maintain a network of postsecondary, campus-based supports throughout Florida, called Positive Pathways for Transitioning Postsecondary Youth (Positive Pathways). Once services are procured, the Positive Pathways provider will complete the following:

- Collaborate with the Department, DOE, Board of Governors and Florida College System to establish dedicated campus coaches for those students eligible for the Tuition and Fee Exemption, as outlined in s. 1009.25, F.S.
- Develop procedures for new member orientation to support the retention of the Positive Pathways Network.
- Provide technical assistance, training and guidance to members, community stakeholders, and former foster youth.
- Organize and deliver a yearly conference for members of the Positive Pathways Network, along with their stakeholders.

ILSAC RECOMMENDATIONS ON HOUSING

After a review of the information related to how the new law has been implemented, and the housing options that exist, THE COUNCIL is making the following recommendations to DCF.

1. There is a lack of data indicating degree of homelessness among foster youth from within DCF. THE COUNCIL recommends that DCF should improve the tracking and monitoring of data to accurately capture how many young adults formerly from foster care are currently homeless.

2. Given the presentation of practices used in Broward County, Palm Beach County and Jacksonville related to Supportive Housing Programs, Housing Coordination and Host Families, DCF should incorporate training of these models as a portion of the statewide Independent Living quarterly meetings and phone calls. Training can include exploring how these models are implemented, outcomes relative to placement longevity and permanent connections of IL youth to supportive adults.

3. DCF should create a plan using the appropriate personnel within DCF to bring uniformity to implementing Aftercare Services, so that community-based care agencies are held accountable for providing services and financial assistance to young adults who are eligible in order to avoid homelessness. This plan can be presented to THE COUNCIL during the 2017 ILSAC meeting schedule.

4. THE COUNCIL recommends DCF improve tracking and monitoring of data to accurately capture how many young adults formerly from foster care are accessing supportive housing options/programs post-age 18. The DCF database (called Florida Safe Families Network) could begin with providing better clarification to case

managers for older foster youth about the types of housing older foster youth are accessing.

DEPARTMENT RESPONSE

Reducing homelessness among youth is one of the six outcome areas tracked by the Administration for Children and Families through the National Youth in Transition Database. The Department and the CBCs also track and monitor the data relevant to housing for young adults receiving independent living services. The Department's Office of Child Welfare, Data Reporting Unit (OCWDRU), developed a report specific to active young adults and their living arrangement type. Young adults are captured in the report, when they are active in FSFN and are linked to an Independent Living Case Type, such as: Road to Independence, Aftercare Support Services, or Young Adults Formerly in Foster Care.

The Department acknowledges that accurate data entry is critical to accurate reporting. In efforts to improve data integrity, the Department makes readily available FSFN trainings and resources. In 2015, the Department launched a FSFN Systems Adoption Initiative to collaborate with each CBC to identify the information and technology requirements and develop an individualized System Adoption Plan. The System Adoption Action Plans were designed to assist the CBCs in achieving enhanced utilization of FSFN, while supporting the agencies' business processes. Within this initiative, guidance papers were issued to assist staff in data entry requirements. The FSFN utilization paper for Independent Living and Life Skills addresses living arrangement types specific to the over-age-18 population. Those living arrangement types include but are not limited to: Foster Family, Group Care, Renting Housing, Own Housing, and Homeless. It is important to note that when a young adult is no longer active, the Department and CBC do not continue to track the young adult's housing status. If a young adult returns requesting service, the young adult's housing needs will be assessed. When a young adult is determined to be eligible for a program and active in the system, the living arrangement will be counted.

Section 39.6251(4), F.S., addresses housing options available to young adults in Extended Foster Care, noting the preference of a licensed foster home over all other options. The Department acknowledges the lack of a sufficient number of licensed foster homes available for youth and young adults in care and supports the exploration of alternative housing programs to serve young adults in transition. While many CBCs have already established or partnered with transitional housing programs, limited supervised housing options remain available statewide. The Department agrees that additional analysis is needed and will explore all opportunities to not only reduce homelessness but to ensure young adults have access to safe and supportive housing.

Aftercare services are intended to be a bridge in or between Extended Foster Care or Postsecondary Education Services and Support. As such, services may vary based on each young adult's level of need. Florida law establishes client eligibility requirements and due process. Requirements in Chapter 65C-42.003, Florida Administrative Code, further detail the framework for how Aftercare Services shall be administered, including: application and discharge procedures, aftercare planning, and documentation requirements. CBCs that are not compliant with these requirements are cited by the Department's Contract Oversight Unit (COU) and required to complete a Corrective Action Plan. The Department will continue to work collaboratively with the CBCs to ensure all independent living program requirements are followed and that eligible young adults are fully engaging in the services available.

ILSAC RECOMMENDATIONS ON PREGNANT AND PARENTING TEENS

1. THE COUNCIL recommends that increased funding be provided to support specialized services, training, and the level of care needed so that youth in Extended Foster Care who are pregnant and parenting can remain in or relocate to quality parenting-driven programs. This funding is imperative to ensure that the youth have access to programs that can enable them to develop the skills they need to successfully parent. The additional funding can come from additional foster care dollars, prevention dollars, and/or other funding sources.

2. It is recommended that as the pregnant or parenting youth transitions to age 18, that the courts ensure "quality" of the case plan by providing follow up. Since there is currently no requirement for follow up, THE COUNCIL is recommending a legislative change that at a maximum of 30 days, DCF and the courts ensure that the expected case plan requirements related to parenting are met. This follow-up must take place to ensure that there is no disruption or discontinuation of services after the youth turns 18. THE COUNCIL is strongly recommending that this language be submitted in DCF's proposed legislation for 2017.

3. It is recommended that DCF provide parenting youth with a Daycare Free Fast Pass. This Fast Pass would provide young parents with absolutely free, flexible, quality daycare that is easily accessible and would remove financial barriers that may prevent a child from attending daycare; therefore, reducing their risk of being abused, neglected and/or abandoned by their young parent.

DEPARTMENT RESPONSE

The Department's policies reflect a mutual concern for pregnant and parenting teens, and recognition of the benefits of support to the teens and their infants. CBCs have the responsibility and authority to approve the living arrangements of those pregnant and parenting young adults participating in Extended Foster Care. Each agency must consider the needs of the young adult and level of supervision, allowing for the young adult to develop the skills necessary to become self-sufficient. All youth in transition should be provided essential life skills, such as parenting, to be successful. The Department will continue to conduct ongoing fiscal analysis of funding to support young adults in Extended Foster Care.

Ongoing transition planning and case planning are mandatory for young adults in Extended Foster Care. These plans should not only address the young adult's long-term goals; they should include a description of the programs and services identified to assist the young adult in becoming successful. The Department will review all statutory and Florida Administrative Code requirements to assess whether additional language is needed in regards to case planning for pregnant or parenting youth.

The Department acknowledges the importance of child care for parenting young adults receiving independent living services. Through the ongoing partnership with the Office of Early Learning (OEL) through the Child Care Program Office and the Quality Child Care for Foster Children Workgroup, the Department will further collaborate with OEL to identify ways to better support parenting young adults seeking child care services. Additionally, the Department will gather feedback from CBC Lead Agencies to determine barriers in accessing quality child care.

ILSAC RECOMMENDATIONS ON EMPLOYMENT

To continue advancing previous COUNCIL recommendations related to employment, THE COUNCIL recommends the following:

1. DCF should develop and adopt operating procedures, definitions of common terms and expectations that emphasize employment as a viable option for youth in out-of-home care who are preparing to transition to adulthood.

2. DCF should enter into a Data Sharing Agreement with DEO and DOR to receive employment status data for youth in care, and provide quarterly updates to THE COUNCIL.

3. DCF should evaluate the current capacity of FSFN, implement necessary system enhancements and program policies to record and track the employment status of all youth who are in care at the state level. If system enhancements are required to collect the data, DCF should approve such enhancements and update the terms of the CBCs' contracts to require that data related to employment be entered in FSFN.

4. Youth employment should be included on the DCF scorecard as a key component of the system of care. DCF should require the collection and use of employment-related data to promote normalcy for youth in dependency care.

5. DCF should revise its Quality Assurance system to evaluate the collection and management of data related to IL youth who are employed. Additionally, IL youth employment should be included in QA reports.

DEPARTMENT RESPONSE

Increasing financial self-sufficiency is one the six outcome areas tracked by the Administration for Children and Families (ACF) through the National Youth in Transition Database (NYTD). Employment is a recognized qualifying activity for participation in Extended Foster Care and is one condition that will help lead transitioning youth to becoming financially independent. The Department would appreciate the Council's leadership in examining with CBCs and external stakeholders, opportunities to increase employment rates among youth in foster care. The Department also will review the appropriateness of establishing performance goals in this focus area.

The Department acknowledges that accurate data entry is critical to accurate reporting. In efforts to improve data integrity, the Department makes readily available FSFN trainings and resources. In 2015, the Department launched a FSFN Systems Adoption Initiative to collaborate with each CBC to identify the information and technology requirements and develop an individualized System Adoption Plan. The System Adoption Action Plans were designed to assist the CBCs in achieving enhanced utilization of FSFN, while supporting the agencies' business processes. Within this initiative, guidance papers were issued to assist staff in data entry requirements. The FSFN Position Paper for Assets and Employment instructs direct service staff to enter information related to earned and unearned income. The Department also will examine a data sharing agreement with the Department of Revenue (DOR) for the purposes

of obtaining employment information for youth in transition. Currently, employment data is available in FSFN and can be accessed for tracking and monitoring. The Department will review whether the information being entered meets the reporting needs or whether FSFN enhancements would be required.

Beginning in October 2016, the Department began a redesign of CBC Performance Monitoring. Through a System of Care review, there will be an integration and synthesis of information from quality case reviews, performance and fiscal data, and special reports. Contract monitoring will include members of the contract oversight unit (COU) and child welfare system experts.

ILSAC RECOMMENDATIONS ON REDUCING THE NUMBERS OF DEPENDENT CHILDREN INVOLVED IN DELINQUENCY COURT

DCF should task a staff person with accomplishing the following recommendations. If there is a Restorative Justice staff member, THE COUNCIL suggests that is the most logical person to be tasked, as the civil citation program is an important component of restorative justice, especially in our schools, which account for a significant percentage of DJJ involvement by our youth.

1. It is necessary to determine why DCF youth have a lower issuance rate of civil citations by working with local law enforcement agencies (LEA) to dispel any myths they may have about children in foster care, and to resolve any real issues they may have with the child welfare system. For example, it may be that LEA do not understand who to contact, or may believe that a foster home will not support a youth in completing citation sanctions. If the latter is true, then DCF should consider mandating support for youth with DJJ involvement, including civil citation sanctions, in its licensing rules and contracts.

2. For those counties which simply do not offer civil citations at all, local CBCs, partnering with DCF and identified local youth advocacy groups, should explore with LEA why this is, and attempt to convince LEA of the benefits of this program.

3. It is also necessary to determine why DCF youth who are issued a civil citation have a lower successful completion rate, and then explore how to resolve this. Some conjectures: the foster parent or group home may not have the ability (or desire) to transport a youth to required sanctions; there may be a lack of communication when a youth with a sanction is transferred to another county for residence. DCF should include civil citation data elements in FSFN to ensure the necessary communication. DCF should also work with the CBCs and CMOs to ensure adequate training of the civil citation program and its requirements and benefits for our youth, and to determine how to better support our youth who are issued citations in successfully completing their sanctions and responsibilities.

4. DCF should work with DJJ at the state level to ensure there is timely sharing of civil citation cross-over data at both the state and local levels.

DEPARTMENT RESPONSE

The Department acknowledges that requirements for criminal records can create a barrier for young adults in obtaining housing, employment, and education. In September 2016, the Department created a Restorative Practices Specialist position to promote integration across the child welfare, juvenile justice, and education systems. In addition, this position serves as the Department's representative on the implementation, training, and ongoing coordination of restorative practices, such as civil citations. The Department agrees that there is a need to increase issuance rates of Civil Citations for youth in foster care and to expand the Civil Citation program for young adults receiving independent living services. The Civil Citation Coordinator for the Department of Juvenile Justice (DJJ) currently collaborates with law enforcement agencies to implement this program and provides training and support. The Restorative Practices Specialist will work closely with DJJ's Civil Citation Coordinator to assist in these efforts.

The Department agrees that there is a need to track the number of crossover youth who are eligible for and receiving Civil Citations. Methods to track and monitor these high-risk youth are being researched through the DCF and DJJ Crossover Youth Workgroup. Data analysis is an integral component of the DCF and DJJ Crossover Youth Workgroup, and monthly data reports are shared and evaluated across both agencies.

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, March 24, 2017

CF OPERATING PROCEDURE
NO. 170-4

Child Welfare

CHILD MALTREATMENT INDEX

1. Purpose. The purpose of the Child Maltreatment Index (Index) is to guide consistent and accurate decision-making by both the Florida Abuse Hotline (Hotline) counselors and field investigation staff. The standards include a definition of each specific maltreatment, factors to consider in the assessment of each maltreatment, frequently correlated maltreatments, excluding factors and the specific documentation needed to verify a maltreatment.

2. Scope. The Index applies to all reports received at the Hotline and all child protective investigations conducted under Chapter 39, Florida Statutes (F.S.).

3. Definitions. For the purposes of this operating procedure, the following definitions shall apply:

a. Abandonment. A situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child, or both. For purposes of this definition, "establish or maintain a substantial and positive relationship" includes, but is not limited to: frequent and regular contact with the child through frequent and regular visitation; frequent and regular communication to or with the child; and the exercise of parental rights and responsibilities. Marginal efforts and incidental or token visits or communications are not sufficient to establish or maintain a substantial and positive relationship with a child. The term does not include a surrendered newborn infant as described in s. 383.50, F.S., a "child in need of services" as defined in s. 984.03(9), F.S., or a "family in need of services" as defined in s. 984.03(25), F.S. The incarceration, repeated incarceration, or extended incarceration of a parent, legal custodian, or caregiver responsible for a child's welfare may support a finding of abandonment. (Section 39.01(1), F.S., and Section 39.01(30)(e), F.S.)

b. Abuse. Any willful act or threatened act that results in any physical, mental or sexual abuse, injury or harm that causes or is likely to cause a child's physical, mental or emotional health to be significantly impaired. Abuse of a child includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child. (Section 39.01(2), F.S.)

c. Allegation. A statement by a reporter to the Hotline that a specific harm or threatened harm to a child has occurred or is suspected to occur. (Rule 65C-30.001(5), Florida Administrative Code (F.A.C.))

d. Harm (Section 39.01(30), F.S.). When a person:

(1) Inflicts, or allows to be inflicted, upon the child physical, mental or emotional injury. In determining whether harm has occurred, the following factors must be considered in evaluating any physical, mental or emotional injury to a child: the age of the child; any prior history of injuries to the child; the location of the injury on the body of the child; the multiplicity of the injury; and the type of trauma inflicted.

(a) Such injury includes, but is not limited to, willful acts that produce the following specific injuries:

1. Sprains, dislocations, or cartilage damage.

2. Bone or skull fractures.

3. Brain or spinal cord damage.

4. Intracranial hemorrhage or injury to other internal organs.

5. Asphyxiation, suffocation or drowning.

6. Injury resulting from the use of a deadly weapon.

7. Burns or scalding.

8. Cuts, lacerations, punctures or bites.

9. Permanent or temporary disfigurement.

10. Permanent or temporary loss or impairment of a body part or function.

(b) As used in paragraph 3d(1)(a) above, the term “willful” refers to the intent to perform an action, not to the intent to achieve a result or to cause an injury.

(2) Purposely gives a child poison, alcohol, drugs or other substances that substantially affect the child’s behavior, motor coordination or judgment, or that result in sickness or internal injury. For the purposes of this definition, the term “drugs” means prescription drugs not prescribed for the child or not administered as prescribed, and controlled substances as outlined in Schedule I or Schedule II of s. 893.03, F.S.

(3) Leaving a child without adult supervision or in an arrangement not appropriate for the child’s age or mental or physical condition, so that the child is unable to care for the child’s own needs or another’s basic needs, or is unable to exercise good judgment in responding to any kind of physical or emotional crisis.

(4) Inappropriate or excessively harsh disciplinary action that is likely to result in physical injury, mental injury as defined in s. 39.01(30), F.S., or emotional injury. The significance of any injury must be evaluated in light of the following factors: the age of the child; any prior history of injuries to the child; the location of the injury on the body of the child; the multiplicity of the injury; and the type of trauma inflicted. Corporal discipline may be considered excessive or abusive when it results in any of the following or other similar injuries:

(a) Sprains, dislocations, or cartilage damage.

(b) Bone or skull fractures.

(c) Brain or spinal cord damage.

(d) Intracranial hemorrhage or injury to other internal organs.

(e) Asphyxiation, suffocation, or drowning.

(f) Injury resulting from the use of a deadly weapon.

(g) Burns or scalding.

(h) Cuts, lacerations, punctures or bites.

(i) Permanent or temporary disfigurement.

(j) Permanent or temporary loss or impairment of a body part or function.

(k) Significant bruises or welts.

(5) Commits or allows to be committed sexual battery, as defined in s. 794.011, F.S., or lewd or lascivious acts, as defined in Chapter 800, F.S., against the child.

(6) Allows, encourages or forces the sexual exploitation of a child, which includes allowing, encouraging or forcing a child to:

(a) Solicit for or engage in prostitution; or,

(b) Engage in a sexual performance, as defined by s. 827.071, F.S.; or,

(c) Exploits a child or allows a child to be exploited, as provided in s. 450.151, F.S.

(7) Abandons the child. Within the context of the definition of "harm," the term "abandoned the child" or "abandonment of the child" means a situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child, or both. For purposes of this definition, "establish or maintain a substantial and positive relationship" includes, but is not limited to, frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the child, and the exercise of parental rights and responsibilities. Marginal efforts and incidental or token visits or communications are not sufficient to establish or maintain a substantial and positive relationship with a child. The term "abandoned" does not include a surrendered newborn infant as described in s. 383.50, F.S., a "child in need of services" as defined in s. 984.03(9), F.S., or a "family in need of services" as defined in s. 984.03(25), F.S. The incarceration, repeated incarceration, or extended incarceration of a parent, legal custodian, or caregiver responsible for a child's welfare may support a finding of abandonment.

(8) Neglects the child. Within the context of the definition of "harm," the term "neglects the child" means that the parent or other person responsible for the child's welfare fails to supply the child with adequate food, clothing, shelter or health care, although financially able to do so or although offered financial or other means to do so. However, a parent or legal custodian who, by reason of the legitimate practice of religious beliefs, does not provide specified medical treatment for a child may not be considered abusive or neglectful for that reason alone, but such an exception does not:

(a) Eliminate the requirement that such a case be reported to the Department;

(b) Prevent the Department from investigating such a case; or,

(c) Preclude a court from ordering, when the health of the child requires it, the provision of medical services by a physician, as defined in s. 39.01(30), F.S., or treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization.

(9) Exposes a child to a controlled substance or alcohol. As used in this definition, the term "controlled substance" means prescription drugs not prescribed for the parent or not administered as prescribed and controlled substances as outlined in Schedule I or Schedule II of s. 893.03, F.S. Exposure to a controlled substance or alcohol is established by:

(a) A test, administered at birth, which indicated that the child's blood, urine or meconium contained any amount of alcohol or a controlled substance or metabolites of such substances, the presence of which was not the result of medical treatment administered to the mother or the newborn infant; or,

(b) Evidence of extensive, abusive and chronic use of a controlled substance or alcohol by a parent when the child is demonstrably adversely affected by such use.

(10) Uses mechanical devices, unreasonable restraints or extended periods of isolation to control a child.

(11) Engages in violent behavior that demonstrates a wanton disregard for the presence of a child and could reasonably result in serious injury to the child.

(12) Negligently fails to protect a child in his or her care from inflicted physical, mental or sexual injury caused by the acts of another.

(13) Has allowed a child's sibling to die as a result of abuse, abandonment or neglect.

(14) Makes the child unavailable for the purpose of impeding or avoiding a protective investigation unless the court determines that the parent, legal custodian or caregiver was fleeing from a situation involving domestic violence.

e. Maltreatment. Behavior that is harmful and destructive to a child's cognitive, social, emotional or physical development. (Rule 65C-30.001(72), F.A.C.) For the purposes of this Index, "maltreatment" is the harm that occurred as the result of the maltreating behavior. There are 27 maltreatments that align with the statutory definitions of abuse, neglect and abandonment.

f. Neglect. When a child is deprived of or is allowed to be deprived of necessary food, clothing, shelter or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental or emotional health to be significantly impaired or to be in danger of being significantly impaired. (Section 39.01(44), F.S., and Section 39.01(30)(f), F.S.)

(1) Neglect of a child includes acts or omissions.

(2) The foregoing circumstances shall not be considered neglect if caused primarily by financial inability unless actual services for relief have been offered to and rejected by such person.

(3) A parent or legal custodian legitimately practicing religious beliefs in accordance with a recognized church or religious organization who thereby does not provide specific medical treatment for a child may not, for that reason alone, be considered a negligent parent or legal custodian; however, such an exception does not preclude a court from ordering the following services to be provided, when the health of the child so requires:

(a) Medical services from a licensed physician, dentist, optometrist, podiatric physician or other qualified health care provider; or;

(b) Treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization.

g. Finding. The determination of whether there is a preponderance of credible evidence supporting the reported harm or threat of harm for each alleged maltreatment. (Rule 65C-30.001(51), F.A.C.)

h. Reasonable Person. A hypothetical person used as a legal standard, especially to determine whether someone acted with negligence; specifically, a person who exercises the degree of attention, knowledge, intelligence and judgment that society requires of its members for the protection of their own and of others' interests. The reasonable person acts sensibly, does things without serious delay, and takes proper but not excessive precautions.

4. Objective. The Child Maltreatment Index incorporates the mandates of state law, administrative code rules and operating procedures applicable to reports of child abuse, abandonment or neglect.

5. Utilization. The Index is a tool to be used by both Hotline counselors and child protective investigators to guide consistent and accurate decision-making.

a. The maltreatment assignment and findings should be based upon the definitions contained in the Index and related to the information obtained by the Hotline counselor and child protective investigator.

(1) Hotline Counselors. The Index supports standard definitions and descriptions of specific types of harm to use in determining whether the reported information meets the criteria for acceptance of an investigation or special conditions report.

(2) Child Protective Investigators (CPI). The Index supports standard definitions and descriptions of specific types of harm to use in determining whether the reported information meets the criteria for verifying child maltreatment.

b. The utilization of the Index enables staff to make informed decisions about the most crucial steps in the investigation process to guide consistent and accurate decision-making related to the determination of findings, which are:

(1) Assessing whether injury or harm exists;

(2) Assessing the nature and severity of reported harm; and,

(3) Determining if the necessary documentation and evidence are present to support all maltreatment findings.

6. Findings.

a. Based upon the Index, the findings are derived from the information obtained during the investigation. Types of documentation that support making an accurate finding are noted in each of the specific maltreatments.

b. Upon completion of the investigation, investigators will reach a determination regarding each of the alleged maltreatments. This determination will be based upon whether information gathered from interviews, records reviews, and observations during the investigation and assessment constitute credible evidence of child abuse, abandonment or neglect by a parent, a legal custodian or, in the absence of the parent or legal custodian, the caregiver.

(1) The findings for each maltreatment type are entered into Florida Safe Families Network (FSFN) as follows:

(a) "Verified" is used when a preponderance of the credible evidence results in a determination the specific harm or threat of harm was the result of abuse, abandonment or neglect.

(b) "Not Substantiated" is used when there is credible evidence which does not meet the standard of being a preponderance to support that the specific harm was the result of abuse, abandonment or neglect.

(c) "No Indicators" is used when there is no credible evidence to support that the specific harm was the result of abuse, abandonment or neglect.

(2) "Preponderance" means the greater weight of the evidence is more likely than not to have occurred.

(3) "Credible Evidence" means evidence that is worthy of belief; trustworthy evidence.

c. Applying the same criteria to qualify as an allegation at Intake, investigators must also add additional maltreatments in the same household of focus that are assessed during the course of an investigation. There should be no call to the Hotline to add maltreatments to an existing Intake under investigation, except for an allegation of "Death." (Rule 65C-29.002, F.A.C.)

d. Although the Hotline uses the maltreatment "Threatened Harm" only for narrowly defined situations, investigators may add this maltreatment to any investigation when they are unable to document existing harm specific to any maltreatment type, but the information gathered and documentation reviewed yields a preponderance of evidence that the child is at real, significant and plausible threat of harm.

7. Maltreatments. There are 27 separate maltreatment types that can be assigned to an abuse or neglect report. Each report of abuse, abandonment or neglect must contain at least one of the

following maltreatment types. There is no limit to the number of maltreatment types that may be included in a report.

Abandonment	Internal Injuries
Asphyxiation	Intimate Partner Violence Threatens Child
Bizarre Punishment	Medical Neglect
Bone Fracture	Mental Injury
Burns	Physical Injury
Death	Sexual Abuse: Sexual Battery
Environmental Hazards	Sexual Abuse: Sexual Exploitation
Failure to Protect	Sexual Abuse: Sexual Molestation
Failure to Thrive/Malnutrition/Dehydration	Substance-Exposed Newborn
Household Violence Threatens Child	Substance Misuse
Human Trafficking – CSEC	Substance Misuse – Alcohol
Human Trafficking – Labor	Substance Misuse – Illicit Drugs
Inadequate Supervision	Substance Misuse – Prescription Drugs
	Threatened Harm

8. Special Conditions Referrals: No Alleged Maltreatment Identified at Intake. There are certain special conditions reported to the Hotline that do not meet the criteria for an investigation but require a response by the Department, the investigating sheriff's office or community-based care (CBC) child welfare professional to assess the need for ameliorative services. The four categories of these reports are defined below. Instructions on the processing of these report types are included in this Index.

a. Caregiver(s) Unavailable. Situations in which the parent(s), legal guardian(s) or caregiver(s) has been incarcerated, hospitalized or has died, and immediate plans must be made for the child(ren)'s care. This referral type also includes situations in which children are unable or unwilling to provide information about their parent(s), legal guardian(s) or caregiver(s). (Section 39.201(1)(a), F.S.)

b. Child on Child Sexual Abuse. Situations of juvenile sexual abuse or inappropriate sexual behavior between two children.

(1) "Juvenile Sexual Abuse" means any sexual behavior by a child (17 years and under) that occurs without consent, without equality, or as a result of coercion. For the purpose of this paragraph, the following definitions apply:

(a) "Coercion" means the exploitation of authority or the use of bribes, threats of force, or intimidation to gain cooperation or compliance.

(b) "Equality" means two participants operating with the same level of power in a relationship, neither being controlled nor coerced by the other.

(c) "Consent" means an agreement, including all of the following:

1. Understanding what is proposed based on age, maturity, developmental level, functioning and experience.

2. Knowledge of societal standards for what is being proposed.

3. Awareness of potential consequences and alternatives.

4. Assumption that agreement or disagreement will be accepted equally.

5. Voluntary decision.

6. Mental competence.

(2) Juvenile sexual behavior ranges from noncontact sexual behavior, such as making obscene phone calls, exhibitionism, voyeurism, and the showing or taking of lewd photographs, to varying degrees of direct sexual contact, such as frottage, fondling, digital penetration, rape, fellatio, sodomy, and various other sexual and sexually aggressive acts. (Section 39.01(7), F.S., and Rule 65C-29.007, F.A.C.)

c. Foster Care Referral. Situations that involve concerns about possible licensing violations, regulatory infractions or the manner of care provided for children in emergency shelter, foster or group homes. They do not contain allegations of abuse, neglect or abandonment. This also applies to individuals over the age of 18 who are placed in the home through extended foster care. (Rule 65C-29.006, F.A.C.)

d. Parent Needs Assistance. Any call received from a parent or legal custodian seeking assistance for himself or herself which does not meet the criteria for being a report of child abuse, abandonment or neglect may be accepted by the Hotline for response to ameliorate a potential future risk of harm to a child. (Section 39.201(2)(a), F.S.)

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

JOSHONDA GUERRIER
Assistant Secretary for
Child Welfare

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

This operating procedure has been updated and reorganized to capitalize on FSFN functionality enhancements.

The “Family Violence Threatens Child” maltreatment was split into “Household Violence Threatens Child” and “Intimate Partner Violence Threatens Child” in order to differentiate between general household violence and violence that involves power and control issues between intimate partners.

Child Maltreatment Index

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Abandonment

Section 39.01(1), F.S., and Section 39.01(30), F.S.

Definition:
"Abandoned" or "abandonment" means a situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child, or both. For the purposes of this operating procedure, "establish or maintain a substantial and positive relationship" includes frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the child, and the exercise of parental rights and responsibilities. Marginal efforts and incidental or token visits or communications are not sufficient to establish or maintain a substantial and positive relationship with a child.

The incarceration, repeated incarceration, or extended incarceration of a parent, legal custodian or caregiver responsible for a child's welfare may support a finding of abandonment.

Examples of Abandonment as a maltreatment:
- Leaving a child with no apparent intention of returning
- Leaving a child with an appropriate caregiver, but failing to resume care of the child as agreed, and the caregiver cannot or will not continue to care for the child
- Refusing to resume care of a child after a family arranged placement breaks down or upon a formal discharge of the child from an institutional or facility setting

Assessing for Maltreatment

Information to inform maltreatment assessment:
- If there is another adult in the home, does the reporter think this adult household member has the ability to protect the child?
- What is the current location of the parent(s), legal guardian(s) or caregiver(s)? Assess and provide detail.
- What is known about the child's needs and how those needs are being met?
- What, if any, is the established authority to provide care for the child?
- What arrangements did the parent or legal guardian make for the support, care and needs of the child? Assess if arrangements continue to be appropriate.
- Were the initial arrangements made by the parent meant to be temporary? Assess for duration established and ability of caretaker to continue to provide for care of the child.
- If the arrangements for the child are not appropriate, assess parental ability and/or willingness to make other arrangements for the child's care, supervision and protection.
- Assess the parent/legal guardian relationship during absence. Determine the frequency of contact with the child and assess the parent/legal guardian's relationship with the child, both prior to the absence and during the absence.
- Assess conditions surrounding the parent/legal guardian's absence. Include information regarding parental functioning.
- Is the parent/legal guardian unwilling or unable to provide care for the child? Detail how the parent/legal guardian is functioning and effects on the ability/willingness to care for the child. (Medical conditions, incarceration, unmanaged mental health, substance misuse, etc.)
- Assess for prior history of parent/legal guardian, including history of providing care.
- Are there known relatives or friends of the family who can provide information? Solicit names and contact information.

Assessing for Frequently Associated Maltreatments:

- Assess for Inadequate Supervision if the parent/legal guardian left the child with a caretaker and the parent/legal guardian was aware the caretaker cannot/will not provide care for the child.
- Assess for Failure to Protect if the parent/legal guardian knowingly left the child with a caretaker(s) who is known to be unsafe, resulting in harm or significant threat of harm to children.

Excluding Factors:

- According to s. 39.01(30)(e), F.S., absent any allegations of abuse or neglect, Abandonment does not include:
  - A "surrendered newborn infant" as described in s. 383.50, F.S.
  - A child who a licensed physician reasonably believes is approximately 7 days old or younger at the time the child is left at a hospital, emergency medical services station, or fire station.
  - A situation in which the only allegation is that the caregiver is late picking up the child from school, daycare or parental custody exchange.

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify a maltreatment, the preponderance of credible evidence will establish that the parent or caregiver has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child. This can be documented through:

- Interview of the alleged child victim
- Interview of the Parents/Legal Guardians, Alleged Perpetrator
- Interview of Household Members
- Interviews with Witnesses/Collateral Contacts
- Analysis of any reports and interviews from law enforcement
- Analysis of prior history to assess for the parent's absence in the child's life
- Documentation of the parent's contact with the child. Assess for frequency, quality and duration.
- Documentation of the CPI and the family's efforts to locate the missing parent
- Information contained in the Maltreatment and Nature of Maltreatment domains are sufficient.

Asphyxiation/Suffocation/Drowning

Section 39.01(30)(a)(1)(e), F.S.

Definition:
A willful act that results in any of the following specific injuries:

Asphyxiation: Unconsciousness or death resulting from lack of oxygen.
Suffocation: To impede breathing by choking, smothering or other mechanical means.
Drowning: To suffocate by immersion in water or another liquid.

"Willful" refers to the intent to perform an action, not to the intent to achieve a result or to cause an injury. *Section 39.01(30)(a), F.S.*

Examples of Asphyxiation/Suffocation/Drowning as a Maltreatment:
- Intentionally drowning a child
- Choking a child
- Holding an object forcibly over a child's mouth, restricting breathing
- Putting a child's head in a toilet bowl, which impedes the child's breathing

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:
- Was the child intentionally choked, suffocated or drowned, regardless of whether a physical injury was present?
- Was the child's breathing impaired due to any of these actions?
- What was the caregiver's physical and mental state prior to, during and after the incident?
- What was the child's physical and mental state prior to, during and after the incident? (Examples: partial or total loss of consciousness, physical injuries to the child, hospitalization or emergency room treatment)

Frequently Associated Maltreatments:
- Assess for "Physical Injury" if there were physical injuries to the child.
- Assess for "Medical Neglect" if any resulting injuries should have received medical treatment and did not.
- Assess for "Bizarre Punishment" if the parent/legal guardian's intent was to punish the child.
- Assess for "Internal Injuries" if the child has brain damage from asphyxiation, suffocation or strangulation.
- Assess for "Bone Fracture" if there were fractured or broken bones (e.g., ribs that may puncture lungs).

Assessing for Maltreatment Findings

Information Necessary to Support a Verified Finding:
In order to verify a maltreatment, the preponderance of credible evidence will establish that the parent/caregiver intentionally restricted the child's breathing through a willful act. This can be documented through:
- Interview of alleged child victim
- Interview of the Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from Law Enforcement
- Assessment of the Child Protection Team

- Prior history with the family as it relates to the current maltreatment and family conditions
- Photographic evidence if any physical injuries that are present
- Documentation of the Medical Examiner's findings if the child died
- Documentation and review of medical records pertaining to the incident
- Review of "911" tapes and recordings of phone calls or conversations from the jail, if available.
- Sufficient information contained in the Maltreatment and Nature of Maltreatment domains.

Bizarre Punishment

Section 39.01(30)(a)(4), F.S., and Section 39.01(30)(h), F.S.

Definition:
Bizarre punishment is a willful act of discipline or punishment that includes inflicting or subjecting a child to intense physical or mental pain, suffering, or agony that is repetitive, prolonged or severe. Bizarre punishment also includes confinement, torture and inappropriate and/or excessive use of restraints or isolation.

"Willful" refers to the intent to perform an action, not to the intent to achieve a result or to cause an injury. *Section 39.01(30)(a), F.S.*

Confinement: Unreasonable restriction of a child's mobility, actions or physical functioning by tying the child to a fixed (or heavy) object, tying limbs together or forcing the child to remain in a closely confined area, which restricts physical movement.

Torture: Deliberately and/or systematically inflicting unusual or bizarre, brutal or cruel treatment and/or severe physical pain as a means of punishment or coercion. This may be a one-time bizarre act as well as a pattern of actions.

Inappropriate/excessive use of restraints or isolation: This is the use of physical or mechanical restraint of a child when there is no threat of injury by the child against himself or herself or to another person; or when the method of restraint or degree of force utilized is not appropriate for the situation (e.g., handcuffs, belts, ropes, etc.).

Examples of Bizarre Punishment as a Maltreatment:
- Tying one or more limbs to a bed.
- Tying a child's hands behind his or her back.
- Forcing a child into a cage.
- Forcing a child to kneel on objects that cause pain (e.g., rice, salt or gravel)
- Tying the child's penis to stop bed-wetting.
- Using instruments to inflict physical pain and suffering (e.g., such bizarre and extreme instruments as chains, knives, tasers, etc.).
- Using restraints as a means of confining the child, refusing access to food, water and use of facilities.
- Locking a child in a closet or small room.
- Confining the child in physical environments that deprives the child of access to food/water and prevents access to others, including during times of emergencies, such as a fire.
- Forcing excessive physical exertion.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:
- If there is another adult in the home, does the reporter think this adult household member has the ability to protect the child?
- What was the frequency and duration of the alleged maltreatment?
- What is the child's current physical, mental and emotional condition?
- What is the child's age and needs?
- What were the parent/legal guardian's actions, responses, and mental and physical state, both during the incident and currently?
- Assess whether the actions were repetitive, increased, prolonged and/or severe.

- What was the parent/legal guardian's reasoning and intent for this action?
- If the child was confined, what was the location and approximate size of the confinement area?
- Did the child have access to assistance, heat and ventilation considerations, presence of lighting and bathroom facilities?
- What were the circumstances regarding the use of restraints?
- What were the physical and emotional effects on the child?
- What was the parent/legal guardian's perception of the need to use restraints?
- Did the child have access to food and water?

Frequently Associated Maltreatments:

- Assess for "Mental Injury" or "Physical Injury" resulting from bizarre punishment.
- Assess for "Medical Neglect" for injuries that should have received medical treatment but did not.
- Assess for "Failure to Protect" if other parent/legal guardian in the household is aware of the parent/legal guardian's actions and fails to provide for protection, despite ability to do so.
- Assess for "Failure to Thrive/Malnutrition/Dehydration" if child has medical manifestations that are a result of deprivation of food and water.
- Assess for "Inadequate Supervision" instead, if the parent/legal guardian is utilizing confinement as a means of providing for supervision of the child while the parent/legal guardian is absent from the home.
- If a child death has occurred due to the confinement, restraint and/or torture, add "Death."

Excluding Factors:

- Brief, unsupervised confinements, such as "time-out," would not constitute Bizarre Punishment.

Assessing for Maltreatment Findings

Information Necessary to Support a Verified Finding:
In order to verify a maltreatment, the preponderance of credible evidence will establish that the parent/caregiver intentionally inflicted intense physical or mental pain, suffering, or agony that is repetitive, prolonged or severe, or that the parent/caregiver subjected the child to confinement, torture and/or inappropriate/excessive use of restraints or isolation. This can be documented through:

- Interview of Victim
- Interview of the Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from law enforcement
- Prior history with the family as it relates to the current maltreatment and family conditions
- Assessment of the Child Protection Team, if referred
- Photographic evidence (if any) of the injuries or environment that appear related to the incident
- Sufficient information contained in the Maltreatment and Nature of Maltreatment domains.

For Institutional Investigations:

- Review documentation from any facility incident reports.
- Consider and analyze state standards and licensing requirements in relation to the action taken.
- Consult with the local Agency for Health Care Administration (AHCA) and/or the Department's Program Office for Substance Abuse and Mental Health (SAMH) regarding the seclusion and restraint licensing standards to determine if the use was within the scope of what is required and allowed.

- Obtain the professional opinion of a physician, psychiatrist or other mental health professional if the caregiver(s) or facility employee contends that confinement or physical restraint was recommended by a medical professional. This opinion must take into account whether the extent of the action was within the limits of the recommendation.
- Review “911” tapes and recordings of phone calls or conversations from the jail, if available.
- Review videos from within the institution.

Bone Fracture

Section 39.01(a)(1)(b), F.S.

Definition:
A bone fracture is any inflicted broken bone in a child that is caused by the willful action of a caregiver(s).

"Willful" refers to the intent to perform an action, not to the intent to achieve a result or to cause an injury. *Section 39.01(30)(a), F.S.*

Examples of Bone Fracture as a Maltreatment:

- A child receives a broken bone after being slammed onto the ground by a parent
- A child receives a skull fracture as a result of the caregiver throwing him/her into a crib
- A child receives a broken bone after a parent deliberately stomps the child's leg/arm/hand
- A child receives a broken bone after a parent hits the child with an object
- A child goes to the emergency room with a broken bone and the parents/caregivers are unable or unwilling to explain the cause of the injury
- A medical provider believes that the explanation provided for the broken bone is inconsistent with the type or severity of the injury.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- What is the explanation given for the injury?
- Is the injury unexplained or is the injury inconsistent with the explanation provided?
- Are there conflicting statements for how the injury was obtained?
- Is there a similar pattern of incidents involving the child, siblings or other children associated with the caregiver?
- What was the reaction and demeanor of the caregiver during the incident or when the history was being taken?

Frequently Associated Maltreatments:

- If the bone fracture occurred as the result of neglect, the maltreatment should apply to the type of neglect (for instance, "Inadequate Supervision" or "Environmental Hazards").
- For injuries involving broken teeth, assess for "Physical Injury."
- Assess for "Medical Neglect" for injuries that should have received medical treatment, but did not.
- Assess for "Failure to Protect" if another parent/legal guardian in the household is aware of the parent/legal guardian's actions and fails to provide for protection, despite the ability to do so.
- Assess for "Inadequate Supervision" if the fracture occurred as a result of the parent/legal guardian or caregiver's failure to provide adequate supervision for the child. Consider the age of the child and the necessity for supervision.

Excluding Factors:

- Accidental bone fractures that are not alleged to be inflicted or the result of inadequate supervision do not constitute "Bone Fracture" as a maltreatment.

Assessing for Maltreatment Findings

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the broken bone was the result of a willful act by the parent/caregiver. This can be documented through:

- Interview of alleged child victim
- Interview of the Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from law enforcement
- Prior history with the family as it relates to the current maltreatment and family conditions
- Assessment of the Child Protection Team (Mandatory Referral)
- Obtaining and analyzing any medical reports to assess for prior injuries, location of fracture, the number of fractures and the aging of fractures
- Photographic evidence (if any) of the injuries or environment that appears related to the incident
- Assessment of the child's development, age and mobility
- Sufficient information contained in the Maltreatment and Nature of Maltreatment domains.

Burns

Section 39.01(30)(a)(1)(g), F.S.

Definition:
A burn is a tissue injury resulting from excessive exposure to thermal, chemical, electrical or radioactive agents from the willful action of the caregiver(s). Intentionally burning a child is a controlled and premeditated action.

"Willful" refers to the intent to perform an action, not to the intent to achieve a result or to cause an injury. *Section 39.01(30)(a), F.S.*

- First Degree (Superficial): Burns or damage limited to the outer layers of the skin.
- Second Degree (Partial Thickness): Burns or damage that extend through the outer layer of the skin into the inner layer. Blistering generally will occur within 24 hours.
- Third Degree (Full Thickness): Burns in which the skin or underlying tissues are charred or destroyed.

Examples of Maltreatment:
- Child submersed in a tub of hot water as punishment for soiling his clothes
- Scalds of the hands or feet, often symmetrical with clear lines of demarcation (e.g., "stocking-glove pattern"), suggesting the extremities were forcibly immersed and held in hot liquid
- Isolated burns of the buttocks or perineum and genitalia or the characteristic doughnut-shaped burn of the buttocks, which in children can hardly ever be produced by accidental means
- Multiple scars in various stages of healing
- One or multiple small, circular burns, in various stages of healing, indicative of wounds created by a cigarette
- Burns inside the lips and on the tongue, with a V-pattern toward the chest, with spared areas near the crease of the mouth and chin, indicative of being forced to drink hot liquid
- Branding
- Oral commissure burn (assess for Inadequate Supervision)

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:
- What is the location on the body, size and description of the burn?
- What was the explanation given of how the injury occurred?
- Is the explanation for the burn consistent with the injury?
- Is the burn of an unknown origin, and does it appear to have been inflicted?
- Why does the person reporting believe it appears to have been inflicted vs. accidental?
- Are there conflicting explanations for the burn? Provide detail.
- Is there a pattern of similar incidents involving the child, siblings, or other children associated with the caregiver(s)?
- What was the reaction and demeanor of the caregiver(s) after the incident? Gather information regarding the parent/legal guardian actions, responses, mental and physical state during the incident and currently.
- What are the circumstances surrounding the incident that caused the injury? What happened just before and just after the incident?
- What is the child's explanation for how the burn occurred?

Frequently Associated Maltreatments:

- Assess for “Inadequate Supervision” instead of “Burns” if the injury was not the result of a willful action.
- Assess for “Physical Injury” for rug, rope or abrasion “burns.”
- Assess for “Medical Neglect” if any resulting injuries should have received medical treatment and did not.

Excluding Factors:

- Accidental burns that were not alleged to be inflicted and in cases when no supervision issues are suspected do not constitute “Burns” as maltreatment.

Assessing for Maltreatment Findings

Information Necessary to Support a Verified Finding:
In order to verify a maltreatment, the preponderance of credible evidence will establish that the parent/caregiver willfully inflicted a burn to a child. This can be documented through:

- Interview of alleged child victim
- Interview of the Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from law enforcement
- Prior history with the family as it relates to the current maltreatment and family conditions
- Assessment of the Child Protection Team (Mandatory Referral)
- Documentation of physical objects that fit the burn pattern (including photographs)
- Medical reports and analysis of the medical reports
- Sufficient information contained in the Maltreatment and Nature of Maltreatment domains.

Death

Definition:
Death is the permanent cessation of all vital bodily functions, which includes: irreversible cessation of cerebral function, spontaneous function of the respiratory system, spontaneous function of the circulatory system, and the final and irreversible cessation of perceptible heart beat and respiration. In order to assign the maltreatment code of death, it must be alleged that the death is the result of abuse or neglect, except in the following circumstances:

- When a child under the age of 5 is found deceased outside of a medical facility and there is no information that the child had been treated for a medical problem that could have caused the death and no clear reason for trauma (such as being the victim of a car accident), the Hotline will accept an intake of "Death," with a secondary maltreatment of "Inadequate Supervision."

- When a child has died in the hospital, and it is suspected that the cause of death or the reason for the hospitalization was abuse or neglect, or if the circumstances surrounding the death are unclear, an intake of "Death" will be accepted with a secondary maltreatment of "Inadequate Supervision." When the reporter has no suspicion that the hospitalization or subsequent death was the result of abuse or neglect, and after a review of the presented facts and prior history there is no cause to suspect maltreatment, then no intake will be generated.

"Death" is an outcome of an act or failure to act, not an actual maltreatment, and therefore cannot be a stand-alone "allegation/maltreatment." A primary causative maltreatment(s) which is believed or suspected to have caused or contributed to the death should be fully assessed.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- Has the child been declared deceased? What is the suspected cause and manner?
- How is the death suspected to have been a direct result of abuse (willful act) by a caregiver(s)?
- How is the death suspected to have been a direct result of neglect (failure to act) by a caregiver(s)?
- What is the most appropriate primary maltreatment?
- What was the caregiver(s)'s demeanor at the time of the child's death? Gather information regarding the parent/legal guardian actions, responses, mental and physical state during the incident and currently.
- Was there a delay in calling 911 or seeking medical treatment for the child?
- Did the caregiver's psychological or emotional health, substance misuse, or violence in the home directly or significantly contribute to the child's death?
- Is the parent/legal guardian or caregiver's explanation of the death consistent with the cause of death, including the type of primary maltreatment, location, and severity? Does the medical opinion support the parent/legal guardian or caregiver's explanation of the cause of death?
- Have any other children in the family died prior to this child's death? If so, what were the circumstances?
- Did the child have a pre-existing illness or medical condition? If so, was there any abuse or neglect associated with the pre-existing illness or medical condition?
- If the reporter is a medical professional, what is the person's medical opinion of the cause of death? If the reporter is not a medical professional, are there any medical professionals available to provide a medical opinion at the time of the report?

Frequently Associated Maltreatments:

- Assess for "Medical Neglect" when the child's death could have been prevented by timely medical attention and treatment.
- For reports of death due to neglect, the Hotline will assess for the appropriate primary maltreatment to add (e.g., "Environmental Hazards," "Inadequate Supervision," "Medical Neglect," etc.).
- For reports of death due to abuse, the Hotline will assess for the appropriate primary maltreatment to add ("Physical Injury," "Burns," "Asphyxiation/Drowning/Suffocation," "Internal Injuries," etc.).

Excluding Factors:

- When a reporter is providing a documented cause of death that is not related to abuse or neglect (for example, a hospital calling in a child who died of leukemia because the hospital's policy is to call in all child deaths), such a situation does not constitute "Death" as maltreatment.
- When a reporter indicates that the child death has been previously reported and investigated, and a Hotline record search locates the prior report in FSFN, such a situation does not constitute a new "Death" maltreatment.
- It is not appropriate to add "Death" as an allegation to an open investigation or an open case in which the family is receiving Family Support or Case Management services when the cause of death is clearly attributable to a pre-existing medical condition or non-preventable accident. In these cases, simply update the person information screen with the date of death.
- The child's death or the incident that led to the death must have occurred in Florida for a maltreatment of "Death" to be used.

Assessing for Maltreatment Findings

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the child died due to abuse, neglect or abandonment and will require an additional maltreatment code to be verified as well. This can be documented through:

- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from law enforcement
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team on the surviving children only (Mandatory Referral)
- Photographic evidence (if any) of the injuries or environment that appears related to the incident
- Documentation from the Medical Examiner
- Information obtained from medical records for the child prior to the child's death
- Information obtained from Emergency Medical Services or other first responders
- Drug screen results
- A detailed timeline of events tied to the caregiver(s)'s activities preceding the death, at the time of the death, and after the child's death
- Sufficient information contained in the Maltreatment and Nature of Maltreatment domains.

Environmental Hazards

Section 39.01(30)(f), F.S., and Section 39.01(44), F.S.

Definition:
Environmental hazards are living conditions or situations that create a significant threat to a child's immediate safety or longer term physical, mental or emotional health due to the actions or non-actions of the caregiver. This includes hazardous conditions and inadequate shelter, clothing or food. Environmental hazards generally are a symptom of deeper, underlying problems with a caregiver's neglect and lack of stimulation. Further evaluation of the caregiver(s) is warranted to determine underlying causes and to determine the significance and impact on child's safety.

- Hazardous Conditions/Drug Labs: The sale, distribution or manufacturing of drugs from a child's residence or in the child's presence. The living conditions could seriously endanger a child's physical, mental or emotional health.
- Inadequate/Hazardous Shelter: The child's living conditions are unsanitary or dangerous to the point that they pose a significant threat to the child's safety or health, as the result of the caregiver(s)'s failure to take action to correct the conditions.
- Inadequate Clothing: The periodic or continuing failure to provide adequate clothing, which creates a serious threat to the child's immediate safety or long-term health and well-being, despite the caregiver being reasonably financially able to do so. This maltreatment is not a measure of style, fashion or quantity, but is meant to ensure that a child has sufficient clothing for his/her health and well-being.
- Inadequate Food: The caregiver(s) has failed to provide or have available adequate amounts of food that, if permitted to continue, is likely to threaten the child's safety, health, development or functioning.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:
A condition may be a significant and serious threat to a younger child (which would qualify for an allegation) but would not be a significant or serious threat to an older child (which would not qualify for an allegation).

- What is the child's: age; medical condition; behavioral, mental or emotional status; developmental disabilities; and/or physical handicaps?
- Has the child's personal appearance deteriorated, including visible or documented weight loss, medical conditions exacerbated by hazards in the home, excessive absences from school and/or daycare?
- Does the parent/legal guardian or caregiver have the resources to provide for adequate shelter, food and clothing? Is the parent/legal guardian or caregiver using those resources for other things (drugs, gambling, etc.) aside from the child's needs?
- Has the caregiver been offered resources or services to improve the circumstances? Were the services accepted by the family? What was the outcome?
- Does the parent/legal guardian or caregiver refuse to provide for food, shelter or clothing despite the ability to do so?
- Has the alleged environmental hazard or condition caused or created a significant danger threat to the child that has or may cause impairment to the child's physical, mental or emotional health, due to the actions or non-actions of the caregiver?
- Is the caregiver's developmental, physical or emotional status a contributing factor?

Clothing:

- Weather conditions, predictability of weather conditions, and parental and child developmental awareness of environmental conditions
- Child displays symptoms of maltreatment due to inadequate clothing (such as having frostbite or extreme sunburn).
- Does the child consistently present with dirty, unkempt, ill-fitted clothing to a level that impacts the child's functioning?

Hazardous Conditions/Drug Labs:

- Drugs are being manufactured within the home.
- Drugs are being distributed within the home and the persons within the home pose a threat of danger to the children in the home due to the distribution.
- Children were present in the home during manufacturing and/or reside in a home where manufacturing activities occur frequently.
- Manufacturing or cultivating of the drugs results in dangerous conditions within the home due to the byproducts produced during manufacturing.
- Chemicals within the home used for manufacturing pose a serious danger threat based upon their toxicity and lethality.

Inadequate/Hazardous Shelter:

- Current status of household utilities. If service has been disrupted, consider the duration of disruption and cause of disruption, associated with medical need of a child (apnea monitor, heart monitor, etc.).
- Description of living environment, including child's space
- Egress is identified and is accessible by household members.
- Age and developmental status of the children
- Access within the home is secured for children who are not developmentally and/or physically able to navigate barriers/safety hazards within the home.
- Parent/legal guardian or caretaker is/is not aware of the home conditions.
- Parent/legal guardian or caretaker has accessed resources to assist in obtaining and/or maintaining shelter.
- Is there a history of hazardous conditions within the home?
- The home/floor is littered pervasively with human or animal feces, and the children are young and crawling on the floor.
- Dangerous or toxic items accessible to children (e.g., weapons, toxic chemicals, cleaning products, etc.)
- Unstable furniture that poses a tip-over hazard

Inadequate Food:

- Has the child been stealing or hoarding food? Is the child asking others for food excessively?
- Does the child appear emaciated given the child's age, height and weight?

Frequently Associated Maltreatments:

- Accept a "Parent Needs Assistance" referral when parent self-reports homelessness and requests assistance caring for his/her child(ren).
- Assess for "Medical Neglect" and "Substance Misuse" when a child is exposed to toxic chemicals or drugs from a home drug lab.
- Assess for "Sexual Abuse" in cases of drug homes, due to the chaotic nature and presence of frequent, unknown visitors to the home.

Excluding Factors:

- An allegation of homelessness in and of itself is not a sufficient reason to accept a report of "Environmental Hazards." The information obtained from the reporter must be thoroughly assessed by the Hotline counselor to make the determination that homelessness is creating a significant threat to child safety.
- The simple absence of food in the home does not, in and of itself, rise to the level of neglect. Reports of "no food" need to be thoroughly assessed for availability, frequency, duration, other contributing factors, other means of sustenance (eating at school, with family, etc.) before making a determination that inadequate food is creating or likely to soon create a significant threat to child safety.

Assessing for Maltreatment Findings

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the child's living conditions or situations create a significant threat to the child's immediate safety or long-term physical, mental or emotional health, due to the actions or non-actions of the caregiver. This can be documented through:

- Interview of the alleged child victim
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals, which may include school teachers, neighbors and the landlord
- Analysis of reports and interviews from law enforcement
- Prior history with the family related to the current maltreatment, similar patterns and family conditions
- Documentation, including photos, of the investigator's observations of the child and environment
- Determination of how much control the parent/caregiver has over the conditions (for example, is the landlord trying to control infestations or make repairs?)
- Documentation or information obtained from other agencies, such as Department of Health, Animal Control, etc.
- Sufficient information contained in the Maltreatment and Nature of Maltreatment domains.

Failure to Protect

Section 39.01(30)(j), F.S.

Definition:
Failure to Protect is failing to protect a child from inflicted physical or mental injury, including failing to protect a child from sexual abuse or exploitation caused by the acts of another. Failure to Protect can include making a child unavailable for the purpose of impeding or avoiding a protective investigation.

Examples of Failure to Protect:

- A caregiver allowing a child to have contact with someone who has previously sexually abused the child when not required by court order to allow contact.
- A parent allowing someone to physically or sexually abuse his/her child when the parent has the ability to prevent the abuse.
- A child victim's parent/legal guardian knew about danger in the other household where maltreatment occurred and did not take actions to protect the child.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- If there is another adult in the home, does the reporter think this adult household member has the ability to protect the child?
- Did the caregiver(s) have the ability to intervene and prevent the harm but did not do so?
- Although the caregiver has the ability to prevent access, is the caregiver(s) continually allowing a paramour or other person access to the child and/or household, and the person's presence is unsafe for the child?
- What knowledge did the caregiver(s)/alleged perpetrator have of prior incidents of abuse or neglect of their child or of other children by the person believed to be a threat to the child?
- Where was the caregiver(s) during the incident?
- Is there a pattern of similar incidents of injury involving this child, siblings or caregiver(s) that would cause a reasonable person to be suspicious of abuse?
- Did the caregiver attempt to impede an investigation by taking the child?

Frequently Associated Maltreatments:

- If there are other types of abuse or neglect that were allegedly committed or omitted (act or failure to act) by a caregiver(s), select those maltreatments in addition to "Failure to Protect."

Excluding Factors:

- Hotline counselors should not add the "Failure to Protect" maltreatment to intakes involving allegations of domestic violence or intimate partner violence.
- The addition of "Failure to Protect" onto intimate partner violence intakes requires verification of the domestic violence victim's active participation in the abuse of the child and is not appropriate as an allegation simply because the victim is still with the perpetrator or the perpetrator is still in the home.

Assessing for Maltreatment Findings

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the parent/caregiver has negligently failed to protect a child when reasonably able to do so. This can be documented through:

- Interview of the alleged child victim
- Interview of Alleged Perpetrator (coordinate with law enforcement, if involved)
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports, call-outs and interviews from law enforcement or State Attorney's Office
- Psychological reports on the caregiver(s) or other professional reports or specialized interviews, preferably from the Child Protection Team
- The Child Protective Investigator may add the "Failure to Protect" maltreatment on reports also verified for "Intimate Partner Violence Threatens Child" that have resulted in harm to the child only after collaborating with the supervisor for appropriateness.

Failure to Thrive/Malnutrition/Dehydration

Definition:
"Failure to Thrive" is a serious, diagnosed, medical condition that is most often seen in young children. The child's weight, length and head circumference, adjusted for gestational age, falls significantly short of the normal lower parameters of typical children of that age. The child's developmental milestones may also be affected by Failure to Thrive, but weight for length is the primary measure.

Malnutrition, like Failure to Thrive, is a serious, diagnosed, medical condition. The child's weight and length fall significantly below the lower normal parameters for the child's age, usually resultant from inadequate intake of protein and/or calories. In some cases, there is an organic cause, such as a medical condition, a genetic error of metabolism or brain damage. Other cases are caused by severe physical and emotional neglect.

Dehydration is caused by inadequate intake of fluids or by excessive loss of fluids, as with severe diarrhea.

For a report to be accepted as "Failure to Thrive/Malnutrition/Dehydration," the allegations must come from medical or nursing personnel and cannot be due to an organic cause.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- What is the child's current weight and length? On the standard growth chart, in what percentile is the child currently for length, height and weight?
- How does the reporter describe the parent-child relationship? Are there additional concerns about physical or emotional neglect? Describe.
- Is the child not growing or has the child lost weight? If so, does the reporter believe this is due to the child being fed insufficient amounts of food due to the parent/caregiver's unmanaged mental health, substance misuse, or cognitive/intellectual/developmental or general parenting knowledge deficiency? Or does the reporter believe this is due to a disturbed parent-child relationship?
- How serious are the child's physical conditions and current health problem?
- What are the child's physical conditions and the seriousness of the current health problem?
- Has appropriate nutrition, hydration, medication or other medically indicated treatment been withheld from the child? Describe knowledge and observations that lead the reporter to this determination.
- What leads the reporter to believe the child's weight loss is due to the child being fed insufficient amounts of food to sustain health and wellness?
- Over what period of time has the weight loss occurred?
- Has there been a decrease in the child's lean body mass or fat? Describe in detail.
- Has there been a change in the child's general appearance, such as thinning hair, paleness, aged skin and/or bulging abdomen? Describe.
- Is the child frequently and repeatedly deprived of meals or frequently and repeatedly fed insufficient amounts of food to sustain health?
- Has there been a change in the child's behavior (e.g., decreased school performance, alteration in consciousness, lack of interest to external stimuli, etc.)? Describe in detail and how this change is associated with parental/caregiver abuse or neglect.
- What is the parent/caregiver's explanation for the child's health and condition resulting in a Malnutrition diagnosis?
- What is the follow-up medical care recommended and the aftercare/discharge plan?

- Is the caller a medical professional? Has the child been diagnosed with Failure to Thrive or Malnutrition?
- Is the caller able to identify that the Failure to Thrive or Malnutrition is non-organic?

Frequently Associated Maltreatments:

- Use the "Failure to Thrive" and "Malnutrition" maltreatment only when the allegation is made by a physician or someone reporting on behalf of a physician.
- Is the child frequently and repeatedly deprived of meals or frequently and repeatedly fed insufficient amounts of food to sustain health, resulting in the Malnutrition diagnosis? If the medical assessment does not support a Malnutrition diagnosis, consider assessing for "Environmental Hazards – Inadequate Food."
- If the child had symptoms that would compel a reasonable person to seek medical care and treatment was not sought, also assess for "Medical Neglect."
- Assess for "Bizarre Punishment" if the caregiver is withholding the child's food for punishment.

Excluding Factors:

- Frequently feeding a child "fast food" does not constitute "Malnutrition" unless the child has a medical condition requiring a special diet, and the child's nutritional needs are not being met.
- Assess for "Environmental Hazards" if the reporter is not a medical professional or does not have the proper medical documentation.

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:

In order to verify this maltreatment, the preponderance of credible evidence will establish that the parent/caregiver, although able to do so, has failed to provide adequate food to the child ***and*** the child has been diagnosed as Malnourished or Failure to Thrive. This can be supported through the following:

- Interview of the alleged child victim
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from law enforcement
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team (Mandatory Referral)
- Documentation of the family's ability to obtain appropriate nutrition for the child
- Documentation from interviewing and/or observing the caregivers and other children in the home, focusing on the nutrition that was provided to the alleged victim and the underlying, contributing factors, such as the age, intellectual capacity, general parenting knowledge of the parent(s), substance abuse of the parent, unmanaged mental health, etc.
- Analysis and review of all medical records
- Review and documentation of any psychological examinations of the caregiver(s) if available.

Household Violence Threatens Child

Section 39.01(30)(i), F.S., and Section 39.01(44), F.S.

Definition:
Household Violence refers to situations in which household members engage in any violent behavior that demonstrates a wanton disregard for a child's safety and/or could reasonably result in injury to the child.

> *"Wanton disregard"* occurs when an alleged perpetrator disregards or lacks capacity to discharge his or her responsibility to provide care to the child. *Wanton disregard* means that an alleged perpetrator has failed to take action in a situation that a reasonable person would know is dangerous in that it subjects a child to an imminent, real and substantial threat of harm and creates a real or plausible threat to child safety.

Examples:
- Household violence involves physical and/or verbal assault on a parent or household member in the presence of a child; the child witnesses the activity and is fearful for his/her own or others' safety as a result.
- Household violence is occurring, and a child is assaulted.
- Household violence is occurring, and a child may be attempting to intervene.
- Household violence is occurring, and a child could be inadvertently harmed by the violence or by intervening during the acts, even though the child may not be the actual target of the violence.

Note: Whether the child is present in the room or home during the alleged incident should not ever be the sole determining factor for accepting or verifying this allegation. This allegation must be fully assessed with regard to present and impending danger given the totality of the information reported, known and determined.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:
- If there is another adult in the home, does the reporter think this adult household member is able to protect the child?
- Have there been any unreported or reported incidents of violence?
- Are there any current or historic protective orders or injunctions? Analyze the details regarding the current or historic protective orders or injunctions.
- Where were the children during the incident(s)?
- Were the children injured as a result of the incident(s)?
- Were weapons used or present during the incident(s)?
- What were the child's physical and emotional conditions during and after the incident(s)?
- Are there any injuries present for any household members, including children? Include severity and location of the injuries.
- Is there any arrest history?

Frequently Associated Maltreatments:

- If a weapon was used during the violent episode and the child was injured with the weapon, also assess for "Physical Injury."
- If a child sustained an injury due to intervening or proximity during a violent episode between other members of the household, also assess for "Physical Injury."
- The only time the alleged perpetrator for this maltreatment can be under 18 is when that minor child is the parent. If the child is attacking an adult in the home, assess for a special conditions "Parent Needs Assistance" referral.
- If assessing for Household Violence and the incident occurred between intimate partners, the assessment must demonstrate that there are no examples of coercive control occurring in the relationship.

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the caregiver has engaged in violent behavior that demonstrates a wanton disregard for a child's safety and/or could reasonably result in injury to the child, or that the caregiver's actions have caused or could cause the child's physical, mental or emotional health to be significantly impaired. This can be documented through:

- Interview of the alleged child victim
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from law enforcement
- Prior history with the family related to the current maltreatment and family conditions
- Observation and documentation of the parent/legal guardian's actions and parent/legal guardian's demeanor following the incident
- Collection and analysis of any injunctions or reports from the court system
- Analysis of local law enforcement's prior responses to the home
- Documentation and communication from the State Attorney's Office of any current or past criminal charges
- Review and documentation of psychological examinations
- Assessment and documentation of any significant negative impacts on the child's daily routines, functioning, development, emotional state, educational and medical needs.
- Observations and interactions between the parents, caregivers and other participants in the incident(s) (if any). Focus should be on their interactions, explanations about the incident(s), and an evaluation of the extent, duration, significance and pattern of the violence, with an assessment of the child's present and impending danger in relation to the behavior of the adult caregiver who is responsible.
- Interview of witnesses of the past or current incidents
- Assessment and documentation of the lethality of the situation (choking, escalating incidents, threats to kill, weapons used, mental/emotional state, pattern, severity, duration, etc.).

Note:

- The arrest of a caregiver should not be the sole evidence used to support or refute a finding of maltreatment. Child protective investigations must assess the broader family dynamics that impact the care and safety of children, not the narrower scope of Florida's criminal code for domestic violence (section 741.28(2), Florida Statutes), which provides for law enforcement responses and investigations.

Human Trafficking – CSEC

(CSEC = Commercial Sexual Exploitation of Children)
Sections 409.1754, 409.1678 and 39.524, F.S.

Definition:
Human Trafficking – Commercial Sexual Exploitation of a Child (CSEC) is the use of any person under the age of 18 for sexual purposes in exchange for anything of value, including money, goods or services, or the promise of anything of value, including money, goods or services.

Victims of trafficking, whether Labor or CSEC, rarely self-disclose. You cannot rely solely on an admission from this victim to support findings. Choice is an illusion when discussing human trafficking. While it may appear that victims have opportunities to leave or ask for help, often the threats, the psychological and emotional manipulation, and the lack of appropriate support systems prevent the child from leaving the situation and often drive the victim back to her/his trafficker, even when the victim is no longer in the situation for a period of time.

Examples of Human Trafficking – CSEC:

- **Renegade/Survival Sex:** There is no third party. No pimp. The victim may "broker" exchanges for a sexual act independently. There may be an exchange of a sexual act for money, food, housing, clothing, etc. Any exchange of a sexual act for any tangible thing, or the promise of a tangible thing, is human trafficking.
- **Pimp Trafficking:** There is a third party who is "brokering" the exchanges of the sexual act for a tangible item, typically money. Pimps can be any age and any gender, and they come from all types of backgrounds.
- **Gang Trafficking:** The trafficking is a source of generating money for the gang, and the gang member is involved in the trafficking of the victim. This might be a local, state, national or transnational gang. A gang is defined as "An association of three or more individuals whose purpose, in part, is to engage in criminal activity."
- **Familial Trafficking:** This is the use or exchange by a family member of a child under 18 for sexual purposes in exchange for or with the promise of anything of value, including money, goods or services.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- Does the child have attendance issues in school?
- Have there been frequent runaway episodes?
- Does the child have a pattern of running away?
- Does the child have "masking criminal charges" (e.g. battery, petty theft)?
- Does the child have a history of abuse or sexual abuse in her/his home of origin?
- Does the child have an older paramour?
- Does the child have involvement with law enforcement for alleged prostitution or human trafficking?
- Does the child show indications of having access to services or products she/he cannot afford (e.g., designer purses, nail and hair services, cell phones, etc.)?
- Does the child have a history of sexual exploitation?
- Does the child have tattoos or indications of branding?
- Has the child been advertised online, such as backpage.com?
- Does the child's online social presence indicate drug use, sexually explicit photos, gang signs or excessive smart phone activity?

Note:

- If the victim is under the age of 18, there is not a requirement for force, fraud or coercion.
- No individual under the age of 18 can consent to an act of prostitution. If the individual is under the age of 18, it is automatically human trafficking.

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify a maltreatment, the information collected would need to show that a child under the age of 18 was used for sexual purposes in exchange for something of value, which can include money, goods or services, or the promise of something of value, such as money, goods or services. This can be established through the following:

- Interview and observation of the alleged child victim
- Interview of Parents, Foster Parents, Household Members/Witnesses/Collaterals
- Documentation from interview and/or observation of the caregiver(s) (if available) and other children in the home with the caregiver(s).
- Documentation from interviewing witnesses to the incident or persons who know the child or caregiver(s) well.
- Documentation that the child has engaged in prostitution or commercial sex acts, which can also be web-based.
- Documentation from any law enforcement reports and interviews and/or from the Juvenile Assessment Center.
- Information obtained from the U.S. Department of Health and Human Services for international victims.
- Legal documentation, such as birth certificates, visas, divorce papers, school records, etc.
- Review and analysis of a completed Human Trafficking Screening Tool (Section 409.1754, F.S., and Chapter 65C-43, F.A.C.)

Human Trafficking – Labor

Definition:
The recruitment, harboring, transportation, provisioning or obtaining of a person for labor or services, through the use of force, fraud or coercion, for the purpose of subjecting that person to involuntary servitude, peonage (where someone is held against his/her will to pay off a debt), debt bondage, or slavery.

There are several forms of exploitative practices linked to labor trafficking, including bonded labor, forced labor and child labor.

> **Bonded labor**, or debt bondage, is probably the least known form of labor trafficking today, and yet it is the most widely used method of enslaving people. Victims become bonded laborers when their labor is demanded as a means of repayment for a loan or service in which its terms and conditions have not been defined or in which the value of the victims' services as reasonably assessed is not applied toward the liquidation of the debt. The value of their work is greater than the original sum of money "borrowed."
>
> **Forced labor** is a situation in which victims are forced to work against his or her own will, under the threat of violence or some other form of punishment, their freedom is restricted and a degree of ownership is exerted. Forms of forced labor can include domestic servitude; agricultural labor; sweatshop factory labor; janitorial, food service and other service industry labor; and begging/panhandling.
>
> **Child labor** is a form of work that is likely to be hazardous to the health and/or physical, mental, spiritual, moral or social development of children and can interfere with their education. The International Labor Organization estimates worldwide that there are 246 million exploited children between ages 5 and 17 involved in debt bondage, forced recruitment for armed conflict, prostitution, pornography, the illegal drug trade, the illegal arms trade and other illicit activities around the world.

Examples of Human Trafficking – Labor:

- Unaccompanied minors with no documentation to support they reside in the United States. Labor trafficking can include bonded labor or debt bondage (where a child incurs a debt he or she is never able to pay off), or involuntary domestic servitude (where a child is forced to work in someone's home for long hours with little or no pay).
- Peddling is a prevalent yet lesser known form of child labor, where children sell cheap goods, such as candy, magazines or other trinkets, often going door-to-door or standing on street corners or in parks, regardless of weather conditions and without access to food, water or facilities.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:
Assess for the totality of the information in determining if there is recruitment, harboring, transportation, provisioning or obtaining of a person for labor or services through the use of force, fraud or coercion, for the purpose of subjecting that person to involuntary servitude, peonage (where someone is held against his/her will to pay off a debt), debt bondage, or slavery.

- Are children being provided what they were promised (e.g., food, wages, water, etc.)?
- In Florida, for door-to-door sales, children under the age of 14 may not be employed and 14- and 15-year-olds must be within an adult supervisor's eyesight. Are they being supervised? Under age 16, they may not work more than 15 hours per week during school session.
- Are children transported to distant cities in a van? Is there a seat for each child? Are they provided food and water? Are they in unfamiliar neighborhoods? Are they being placed in dangerous environments?
- Describe the specific labor or services that child is being forced to participate in.
- Is debt bondage described? (Debt bondage is when a person under control of another person promises to pay money owed with his or her labor or through the personal services of a child under his or her control as a security for debt.)
- Are threats being made to the child or the child's parents or siblings?
- Is the child being threatened with deportation?
- Was the child given false promises of reunification with family, citizenship, education or eventual independence?
- Is the child isolated (e.g., not attending school, no access to telephones or friends, etc.)?
- What is the alleged perpetrator's legal relationship to the child?
- If the adult "responsible" alleges that the child was placed in his/her custody through a "family arrangement," does the alleged victim have an ongoing contact with her/his biological parents?
- Did the parents/legal guardians condone or make no efforts to stop another non-caregiver(s) from exposing the child to these behaviors or activities?
- Is food being withheld from the child or used as a means of control and threat?
- Is the child being physically confined as a means of controlling the child's access to others?
- Is drug and/or alcohol dependency being used by the perpetrator to control the child?
- Can the adults "responsible" for the child produce documentation legitimizing their role as legal caregivers (such as birth certificate, visa, divorce papers, school records, etc.)?
- Can the child identify or describe specific familial connections with the adult said to be responsible for his/her well-being (such as names of relatives, how family members are related, etc.)?
- Can the child describe traditional familial interactions with the caregiver(s) in the past (such as birthday parties, holiday celebrations, etc.)?
- Did the adults "responsible" flee when the child was reported or taken into custody?

Traffickers use various techniques to control their victims and keep them enslaved. Some traffickers hold their victims under lock and key. However, the more frequent practice is to use less obvious techniques, including:

- Debt bondage – enormous financial obligations or undefined/increasing debt
- Isolation from the public – limiting contact with outsiders and making sure that any contact is monitored or superficial in nature
- Isolation from family members and members of the victim's ethnic and religious community
- Confiscation of passports, visas and/or identification documents
- Use or threat of violence toward victims and/or family members

- The threat of shaming victims by exposing circumstances to family
- Telling victims they will be imprisoned or deported for immigration violations if they contact authorities
- Control of the victims' money (e.g., holding their money for "safe-keeping")

Excluding Factors:

- Unrealistic or excessive “chores” required by parents of their children should be assessed for “Bizarre Punishment” or “Mental Injury,” not “Human Trafficking – Labor.”

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify Human Trafficking – Labor, the information collected will need to support that a child was used for recruitment, harboring, transportation, provisioning or obtaining of a person for labor or services, through the use of force, fraud or coercion, for the purpose of subjecting that person to involuntary servitude, peonage (where someone is held against his/her will to pay off a debt), debt bondage or slavery. This can be established through the following:

- Interview, observation and documentation with the alleged child victim
- Interview with persons believed to be responsible for the child’s care and welfare
- Documentation from any reports and interviews from law enforcement and/or the Juvenile Assessment Center
- Information obtained from the Department’s Refugee Services
- Information obtained from the U.S. Department of Health and Human Services
- Legal documentation, such as birth certificates, visas, divorce papers, school records, etc.
- Documentation from interview and/or observation of the interactions between the parent, legal guardian, caregivers and the child and other children in the household

Inadequate Supervision

Section 39.01(30)(a)(3), F.S.

Definition:
Inadequate supervision means a parent/caregiver leaving a child without adult supervision or arrangement appropriate for the child's age, maturity, developmental level or mental or physical condition, so that the child is unable to care for the child's own needs or another's basic needs, or is unable to exercise sufficient judgment in responding to a physical or emotional crisis.

There is no age stated in Florida Statute at which a child can be left unattended or alone. There are also no established timeframes for how long a child of any given age can be left alone. These are primarily parental decisions and, as such, each situation must be assessed individually, focusing on:

- The specific child, caregiver(s), and incident factors given the child's age, maturity, developmental level, or mental or physical condition;
- The child's ability to care for his/her own needs or another's basic needs; and
- The child's ability to exercise sufficient judgment in responding to any physical or emotional crisis.

This maltreatment also would apply when a parent/caregiver is present but has a history of or is currently exhibiting signs of unmanaged mental health, delusional behavior, immaturity, developmental delays, or other limitations that have resulted in harm, or pose a threat of harm, to a child.

Examples:

- A caregiver leaving his/her 6-month-old home alone while the caregiver goes grocery shopping.
- A caregiver leaving a toddler alone in a car.
- A caregiver leaving a young child alone in a bathtub while he/she goes to the other room to talk on the phone.
- A caregiver leaving his/her child in the care of a registered sex offender.
- A caregiver whose unmanaged mental health has caused the caregiver to not attend to a child's daily needs.
- A caregiver who is exhibiting serious signs of unmanaged mental health issues or cognitive delays while caring for a child.
- Deadly weapons or medications are readily accessible to a child.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- If there is another adult in the home, does the reporter think this adult household member has the ability to protect the child?
- Is the child currently without supervision? How long has the child been left without supervision, and what is the location of the child at the time? (Also, consider 911 emergency response, depending upon circumstances.)
- Assess the child's age, maturity and developmental level. Consider the child's ability to make judgments regarding safety.
- What is the frequency, time of day(s), and duration of the child not having adult or other arranged supervision?
- Where are the parents when the child is without adult or other arranged supervision? What is/was their anticipated return?
- Is the parent/legal guardian or caregiver's contact information available to the child, and does the child have the means and ability to access the parent/legal guardian or other caregivers?
- What is the child's means and ability to respond in an emergency (e.g., fire, injury, someone knocking on the door, etc.)?

- Is the caregiver accessible by telephone and is the child mature enough to know when and how to use the telephone to contact the caregiver(s)?
- How accessible is the caregiver to the child? Can the caregiver(s) see and/or hear the child?
- Have sufficient food and provisions been left for the child?
- Is the caregiver out of direct supervision of the child while there are factors that create threat of immediate or impending danger or risk of future harm based on the age, maturity, developmental level, or disabilities of the child (for example, younger child riding a bicycle in the street after dark or a caregiver leaving an infant in a bathtub)?
- Has a child been left alone when he/she has a condition that requires close supervision, such as a medical condition, behavioral, mental or emotional problems, developmental disabilities, or physical disabilities?
- Has the child been left at home alone or unattended in an unsafe place?
- Is the child on medication that cannot or should not be self-administered?
- Has the caregiver arranged for inappropriate or inadequate secondary caregiver(s) with a known history of violence, substance abuse, emotional instability, immaturity, sexual offending, or other limitations such as age, which affect the caregiver's ability to care for the child?
- Were potentially dangerous objects (unsecured weapons, medications, etc.) left accessible to the child?
- Was the child injured as a result of inadequate, negligent supervision?

<u>If someone is currently with the child</u>:

- Who is taking care of the child?
- Can the child remain with this adult or person, or is intervention needed now? Why?
- How often is the child left alone, and when does this usually happen?
- Does someone check on the child when alone? Who? How can we contact him/her?
- Does the child or sitter/care provider know how to contact a parent? Does the child or sitter/care provider have the means to do so (phone, email, etc.)?
- How did the sitter/care provider currently with the child come to be responsible for watching this child (informal arrangement, circumstances dictated for child safety – person saw young infant by side of road, etc.)?

<u>If the parent/legal guardian or caregiver is present but appears delusional or psychotic</u>:

- If the parent/legal guardian or caregiver is present and there are concerns for supervision due to possible diminished functioning of the parent, describe the behavior, actions and statements that the caregiver has made/is making.
- Is the caregiver making comments that would be considered irrational?
- Does the caregiver have an untreated or unmanaged serious and persistent mental health diagnosis that prevents the caregiver from providing adequate care and supervision for the child?

Additional screening questions that must be asked by the Hotline counselor or child protective investigator:

Screening Questions

1. **Are there behavioral indicators you have witnessed or that have been reported to you about the caregiver?** (delusions, hallucinations, disorganized thinking, disorganized speech, paranoia, flat affect, major depression, manic episodes)

    - Delusions – false beliefs that are not part of the person's culture and do not change (neighbors can control his or her behavior; people on television are directing special messages to him or her)
    - Hallucinations – things a person sees, hears, smells or feels that no one else can see, hear, smell or feel. (He or she may hear voices that tell him/her to do things, or the voices may talk to each other.)
    - Disorganized thinking – when a person has trouble organizing his or her thoughts or connecting them logically (the person may talk in a jumbled way that is hard to understand)
    - Disorganized speech – when a person's thought process is disorganized and, therefore, it can be difficult for the individual to express his/her thoughts clearly (e.g., rambling responses unrelated to the question asked)
    - Paranoia – preoccupation with one or more delusions (a person may think someone is following him, or she might think her phone has been bugged, etc.)
    - Manic Episodes – excessive energy, euphoria, over-activity (talking very fast, being easily distracted, increasing activities, sleeping little or not being tired, behaving impulsively)

2. **If so, do you believe these behavioral indicators/observations may place the child in immediate or impending danger or at risk of harm? Why?**
3. **What has the person said or done to indicate a serious unmanaged mental health/behavioral concern?**
4. **Has the person made statements that they plan to harm the child, themselves, or others? Do they have the means to carry out the plan?**
5. **Is there a history of any of these behaviors or unmanaged mental health concerns in the past? (If so-what are the details?)**
6. **Is the child currently in the care of the individual demonstrating the concerning behavior? Is the person the primary caregiver?**
7. **When did this occur? (current, past, and frequency/pattern of behavior)**

Source: National Institute of Mental Health. Retrieved January 9, 2015, from http://www.nimh.nih.gov/index.shtml; American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

Frequently Associated Maltreatments:

- When there is an allegation of inadequate supervision due to alcohol or substance abuse, also assess for the "Substance Misuse" maltreatment.

Excluding Factors:

- When the only allegation is that the caregiver is late picking up the child from school, daycare or parental custody exchange, such a situation does not constitute "Inadequate Supervision."
- Situations concerning licensing violations, such as overcrowding, poor sanitation, inadequate staffing ratios, and lack of a fire sprinkler system do not constitute "Inadequate Supervision." (*Rule 65C-29.002, F.A.C.)*
- Situations of school truancy do not constitute "Inadequate Supervision." However, truancy can often be an indication of abuse or neglect. If after a thorough assessment there is insufficient information to initiate a report of abuse, these complaints shall be directed to the local school board. *(Rule 65C-29.002, F.A.C.)*
- Contacts from service workers regarding the placement disruption of a child in out-of-home care, whether the child is in a licensed or non-licensed relative or non-relative placement, do not constitute "Inadequate Supervision." *(Rule 65C-29.002, F.A.C.)*
- Calls or disputes concerning child custody and visitation issues do not constitute "Inadequate Supervision." *(Rule 65C-29.002, F.A.C.)*
- Complaints of withholding or misuse of child support do not constitute "Inadequate Supervision." *(Rule 65C-29.002, F.A.C.)*
- Complaints concerning infants or children in automobiles who are not in legally required child restraint devices do not constitute "Inadequate Supervision." *(Rule 65C-29.002, F.A.C.)*
- A situation concerning children running away from parents or legal custodians; persistently disobeying reasonable and lawful demands of parents or legal custodians; and being out of control is not, in and of itself, "Inadequate Supervision." Counselors and investigators must fully assess situations in which the parent, legal custodian or caregiver has locked an older child out of the home due to these behaviors or is refusing to pick up a child who has been placed in a facility for those behaviors. If a child in this situation is involved with the Department of Juvenile Justice (DJJ), the Hotline, pursuant to the Interagency Agreement between DJJ and DCF, shall refer these children to DJJ for their due diligence related to placement and services. *(Rule 65C-29.002, F.A.C.)*

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:

In order to verify this maltreatment, the preponderance of credible evidence will establish that the child was in a situation where the child would have to meet his/her own basic needs and, based on the child's specific vulnerabilities, was unable to do so. This can be confirmed by the following:

- Interview of the alleged child victim
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from law enforcement, including calls for service
- Prior history with the family related to the current maltreatment and family conditions
- Investigator's observations and assessment of the child and environment, demonstrated ability to provide for reasonable self-care, access to others, etc.
- Documentation of harm that occurred or was likely to occur (present or impending danger), based upon the totality of circumstances and history
- Assessment of the impact of alcohol or drug use on the adult caregiver's ability to provide appropriate or safe supervision of the child.
- Assessment of the impact of the adult caregiver's mental health and his/her ability to provide appropriate or safe supervision of the child

- Assessment and evaluation of severity, duration and pattern of such incidents in direct relation to the child's ability and functioning
- Documentation of the environment, which may include photographic evidence
- Consideration of patterns of similar incidents of concerns related to supervision involving the caregiver(s)
- Circumstances which may be contributing to the caregiver's ability to supervise the child with significant impact or impending danger to the child.

NOTE: If the parent/legal guardian or caregiver is experiencing delusional or psychotic behaviors, in areas where mobile crisis teams exist, the child protective investigator will request an immediate response upon receipt of the report. Contact your regional Substance Abuse and Mental Health Director for a list of your local crisis teams.

Internal Injuries

Section 39.01(30)(a)(1)(d), F.S.

Definition:
An internal injury is an injury caused by a willful act by a caregiver to the organs occupying the thoracic (chest), cranium or abdominal cavities that is not visible from the outside. Internal injuries may be accompanied by other external injuries. A person so injured may be pale, cold, perspiring freely; have an anxious expression; seem semi-comatose; or exhibit other symptoms, such as lethargy, disorientation, blood in bowel movements or urine, and/or loss of consciousness.

"Willful" refers to the intent to perform an action, not to the intent to achieve a result or to cause an injury. *Section 39.01(30)(a), F.S.*

Examples:
- Brain or Spinal Cord Damage: Injury to the nerve tissue contained within the cranium/skull or spinal cord.
- Intra-Cranial Hemorrhage: An abnormal collection of blood within the skull, including subdural, subarachnoid, or epidural hematoma and intra-cerebral hemorrhage (often associated with abusive head trauma, retinal hemorrhage, Shaken Baby Syndrome, etc.).
- Lacerated spleen, kidney, liver, pancreas, or bowels/intestines.
- Penetrating injuries from stabbings or gunshot.

For a report to be accepted as "Internal Injuries," the allegations must come from medical or nursing personnel and cannot be due to an organic cause.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- Is the caller alleging that the internal injury occurred by an intentional, willful act or accidentally? Explain and detail.

Frequently Associated Maltreatments:

- If the child had symptoms that should have caused a reasonable person to seek medical care and such medical care and treatment was not sought, also assess for "Medical Neglect."

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the child received internal injuries as the result of a willful act by the caregiver. This can be established through:
- Interview of the alleged child victim
- Interview of the Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Documentation related to when the symptoms first appeared and what action was taken by the caregivers
- Analysis of law enforcement reports and interviews
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team (Mandatory Referral)

- A detailed timeline of events tied to the caregiver(s)'s activities preceding the injury, at the time of the injury, and after the child's injury.
- Photographic evidence of the injuries and/or environment that appear to be related to the incident
- Information obtained from Emergency Medical Services or other first responders.

Intimate Partner Violence Threatens Child

Section 39.01(30)(i), F.S., and Section 39.01(44), F.S.

Definition:
Intimate Partner Violence includes the dynamics of establishing power, control or coercion perpetrated by one intimate partner over another that includes actions that have caused, or could cause, the child's physical, mental or emotional health to be significantly impaired. The volatility and lethality of this dynamic are differentiated from other types of family or household violence or aggression, and requires a specific assessment.

Examples:
- Parent/caregiver has isolated the other parent/caregiver by controlling daily activities, and the child has been maltreated as a result.
- Parent/caregiver has economically controlled the parent/caregiver by maintaining sole access to finances or modes of transportation, and the child(ren) has been maltreated as a result.
- Parent/caregiver uses threats or implied threats of violence against children to control the other parent/caregiver.
- Parent/caregiver has taken or hidden children from the other parent/caregiver.
- Parent/caregiver has committed acts of physical violence against the other parent/caregiver or child(ren).
- Parent/caregiver has emotionally abused the other parent/caregiver by using derogatory language, calling names or undermining parenting, and the child has witnessed and has suffered mental injury.
- Parent/caregiver has interfered with the other parent/caregiver's access to medical treatment for the child(ren).
- Parent/caregiver has displayed weapons in a threatening manner in the presence of the other parent/caregiver or child(ren).
- Parent/caregiver has interfered with the other parent/caregiver's attempts to provide for the daily needs of the child(ren).

Note: Whether the child is present in the room or home during an alleged incident should not ever be the sole determining factor for accepting or verifying this allegation. This allegation must be fully assessed with regard to present and impending danger given the totality of the information reported, known and determined.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:
- What is the perpetrator's pattern of coercive control? For example: Does the perpetrator call the survivor at work frequently to check up on her/him, restrict the survivor's freedom, control all of the finances, or isolate her/him from friends and family members?
- What actions has the perpetrator taken to harm the child?
- What is the adverse impact of the perpetrator's behavior on the child?
- Has the batterer made any threats to the survivor or the children?
- Where is the child during the incidents, and what are the child's physical and emotional conditions during and after the incident(s)?

- Are there any injuries present for any household members, including children? Include severity and location of the injuries.
- Are there any current or historic protective orders or injunctions? Analyze details regarding the current or historic protective orders or injunctions.
- Is there any arrest history?

Frequently Associated Maltreatments:

- When assessing a perpetrator's pattern of coercive control, explore the ways in which the perpetrator's actions have harmed the children, and add any appropriate maltreatment codes.
    - If a weapon was used during the violent episode and the child was injured with the weapon, also assess for "Physical Injury,"
    - If a child sustained an injury due to intervening or proximity during a violent episode between other members of the household, also assess for "Physical Injury."
    - If the child has shown a discernible and substantial impairment in the ability to function within the typical range of performance and behavior as a result of witnessing or experiencing the dynamics of intimate partner or domestic violence, also assess for "Mental Injury."
    - If the perpetrator's pattern of control involves monetary restrictions that have resulted in the child's needs not being met, also assess for "Environmental Hazards."
- The only time the alleged perpetrator for this maltreatment can be under 18 is when that minor child is the parent. If the child is attacking an adult in the home, assess for a special conditions "Parent Needs Assistance" referral.
- Hotline counselors should not add the "Failure to Protect" maltreatment to intakes involving allegations of intimate partner or domestic violence.

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the caregiver has exhibited dynamics of power, control, or coercion over the adult survivor, including actions that have caused or could cause the child's physical, mental or emotional health to be significantly impaired. This can be documented through:

- Interview of the alleged child victim
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from law enforcement
- Prior history with the family related to the current maltreatment and family conditions
- Observation and documentation of the parent/legal guardian's actions and parent/legal guardian's demeanor following the incident
- Collection and analysis of any injunctions or reports from the court system
- Analysis of local law enforcement's prior responses to the home
- Documentation and communication from the State Attorney's Office of any current or past criminal charges
- Review and documentation of psychological examinations
- Assessment and documentation of any significant negative impacts on the child's daily routines, functioning, development, emotional state, educational and medical needs.
- Observations and interactions between the parents, caregivers and other participants in the incident(s) (if any). Focus should be on their interactions, explanations about the incident(s), and an evaluation of the extent, duration, significance and pattern of the violence, with an assessment

of the child's present and impending danger in relation to the behavior of the adult caregiver who is responsible.
- Assessment and description of intimate partner violence behaviors (power, control and/or coercion) as disclosed by the adult survivor and/or child
- Interview of witnesses of the past or current incidents
- Assessment and documentation of the lethality of the situation (choking, escalating incidents, threats to kill, weapons used, mental/emotional state, pattern, severity, duration, etc.).

Note:
- The arrest of a caregiver should not be the sole evidence used to support or refute a finding of maltreatment. Child protective investigations must assess the broader family dynamics that impact the care and safety of children, not the narrower scope of Florida's criminal code for domestic violence (s. 741.28(2), F.S.), which provides for law enforcement responses and investigations.

- It is imperative that child welfare professionals document the demeanor of the victim/perpetrator with the understanding that many victims are angry or upset after a violent incident, but this does not mean they are the primary aggressor or that the violence is mutual. Also, perpetrators are skilled at manipulation, so they know how to present well in front of others and appear to be the "responsible" parent, while the victim looks angry, out of control, hysterical, etc. Physical aggression in response to acts of violence may be a reaction to or self-defense against violence, or a protective action to "provoke" the physical aggression when the children are not around or are in a safe location. For purposes of child protective interventions, it is important to accurately identify the underlying causes of the violence and whether or not the dynamics of power and control are evident.

Medical Neglect

Section 39.01(41), F.S.

Definition:
"Medical neglect" means the failure to provide or the failure to allow needed care as recommended by a health care practitioner for a physical injury, illness, medical condition, mental health condition, or impairment, or the failure to seek timely and appropriate medical/mental health care for a serious health/mental health problem that a reasonable person would have recognized as requiring professional medical/mental health attention.

Examples:
- A caregiver does not give a diabetic child prescribed insulin or ensure that the child is effectively administering the insulin.
- A caregiver purposefully delays medical attention for a child with a serious injury.
- A mental health or medical professional reports that a caregiver does not ensure a child's psychiatric needs are being met.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:
- How serious are the child's physical conditions and current health/mental health problem?
- What is the medical prognosis if the current health/mental health problem is not treated?
- What is the parent/caregiver's explanation for not getting treatment for the child?
- Does the child's age (newborn infant) or medical condition (HIV positive, Drug Exposed Infant withdrawal, etc.) make him/her especially vulnerable to inadequate nutrition, hydration, medication, or other medically indicated treatment?
- Is a diaper rash being reported that has open or bleeding lesions that require professional medical attention, and no such attention has been provided?
- Does the caregiver(s) fail to use a medical device (apnea monitor, etc.) prescribed by a physician, which is likely to result in serious harm to the child?
- When a caregiver refuses to allow a newborn to be tested for HIV and the mother has been diagnosed as HIV-positive, a report shall be accepted by the Hotline only when called in by a medical professional.

Frequently Associated Maltreatments:
- When the caregiver fails to provide for medical care to treat an inflicted injury, also assess for "Physical Injury."
- Medical neglect does not occur if the parent or legal guardian of the child has made reasonable attempts to obtain necessary health care services or the immediate health condition giving rise to the allegation of neglect is a known and expected complication of the child's diagnosis or treatment, and:
  - (a) The recommended care offers limited net benefit to the child, and the risk of morbidity or other side effects of the treatment may be considered to be greater than the anticipated benefit of treatment; or,
  - (b) The parent or legal guardian received conflicting medical recommendations for treatment from multiple practitioners and did not follow all recommendations.
- A lack of immunizations under current law does not constitute medical neglect.
- Minor medical conditions which under usual conditions have limited potential for serious or long-term harm (such as colds/flu, sunburn, ADHD medication, dental cavities, head lice, etc.) do not constitute "Medical Neglect" unless the continued failure to treat the condition is likely to result in serious harm (e.g., untreated dental care leading to abscess, infection or gum disease, etc.).

- Not providing medication for a child diagnosed with ADHD or ADD does not constitute “Medical Neglect.”
- Failure to provide appropriate routine medical care due to lack of financial ability alone is not medical neglect, unless actual relief has been offered and refused. However, in cases of emergency medical services, financial ability is not a determining factor.
- Caregivers who, by reason of legitimate practice of religious beliefs, in accordance with a recognized religious organization, do not provide specified medical treatment for a child may still be considered abusive or neglectful. Legitimate practice based on religious beliefs does not eliminate the requirement that such a report be made to the Hotline, nor does it prevent the Department from conducting an investigation to determine harm and caregiver responsibility.

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the parent/caregiver failed to seek medical care for a child that a reasonable person would have deemed necessary. This can be supported through the following:

- Interview of the alleged child victim
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of law enforcement reports and interviews
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team (Mandatory Referral)
- Review and documentation of the child’s prior medical history and how/if follow-up was completed by the caregiver
- Documentation of the proper administration of prescribed medications, including pill count, purpose of the prescription, what happens if the child does not take the medication, and the potential harm of not taking the medication as prescribed?
- Documentation of the long-term potential harm due to the non-treatment.
- Documentation from interviewing the caregivers on their ability to understand the child’s health needs and to respond to those needs.

Mental Injury

Section 39.01(42), F.S.

Definition:
A mental injury is an injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability to function within the normal range of performance and behavior, or when a child exhibits symptoms of serious emotional problems when emotional or other abuse, abandonment, or neglect is suspected.

Examples:

- A parent alienating a child from another parent, resulting in substantial impairment to the child
- A parent making an older child wear a diaper and drink from a bottle (act like a baby) after bed-wetting
- A parent shaving a young girl's head as punishment for talking to a boy. The girl is ridiculed at school and then breaks down crying daily before going to school.
- A child is isolated in a household, closed in his room with only a mattress, windows painted and sealed shut, not allowed to exit the room except to use the restroom
- A child is caged or subjected to extreme ridicule by a caregiver who documents every infraction a child makes and finds fault in the child's existence (could also be "Bizarre Punishment")
- Parent ridicules a child's sexual orientation or physical anatomy (including any anomaly) privately or publicly.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- If there is another adult in the home, does the reporter think this adult household member has sufficient parental protective capacities to protect the child? Why or why not?
- Is there discernible, observable or probable impairment of the child's ability to function as he or she normally functions?
- Has there been a noticeable change in the child's behavior based upon action of the caregiver(s)? Assess further.
- Do the caregivers' actions inappropriately restrict the child's autonomy or independent learning? Detail.
- Have statements been heard by the child that reflect unrealistic or unreasonable expectations of the child given the child's developmental level? What are they?
- What are the patterns of acts or verbal mistreatment directed at the child by the caregiver(s)?
- Describe any willful violent acts directed toward a child's pet, possessions or environment.
- Is the child exposed to repeated violent, brutal or intimidating acts or statements among household members? If so, what has been the impact to the child intellectually, psychologically or behaviorally?
- Is the child demonstrating self-mutilating behaviors or suicidal ideations that are believed to be the result of the caregiver(s)' statements or actions?

Frequently Associated Maltreatments:

- If there are other types of abuse or neglect that were allegedly inflicted by the caregiver(s), select those maltreatments in addition to "Mental Injury." Often, maltreatments associated with "Bizarre Punishment" will have a correlating maltreatment in addition to "Mental Injury."
- Temporary unhappiness or a distress reaction alone due to the caregiver(s)'s statements or actions does not constitute "Mental Injury."

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the child has been significantly impaired psychologically or intellectually due to the actions or inactions of the parent or caregiver, or that the child is showing symptoms of serious emotional problems when emotional or other abuse, abandonment, or neglect is suspected. This can be shown through the following:

- Interview of the alleged child victim
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of law enforcement reports and interviews
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team (Mandatory Referral)
- Supportive documentation from other licensed professionals, which may include physicians, psychiatrists, psychologists or other licensed mental health professionals
- Review and documentation of the child's prior mental health history and how/if the child received treatment
- Consideration of any reports and interviews from law enforcement, including call-outs.
- Documentation on whether the child's ability to function has been discernibly and substantially adversely affected, comparing prior functioning level to the child's current level
- Documentation from interviewing the child, siblings, caregiver(s), and other relevant sources familiar with the family's situation.

Physical Injury

Section 39.01(56), F.S., and Section 39.01(30)(a)(1) & (4), F.S.

Definition:
Physical injury includes a willfully inflicted physical injury to a child that results in temporary or permanent disfigurement, temporary or permanent loss or impairment of a bodily part or function, or is an action that is likely to cause a physical injury, a threat to a child's safety or a real, plausible and significant threat to the child's physical, mental or emotional health.

> *Plausible threat* of physical injury means that the parent or caregiver has acted, or is acting, in a manner that creates a probability of physical injury that would cause the child severe pain or significantly impair the child's physical functioning either temporarily or permanently.

Definitions of injuries covered in "Physical Injury" are as follows:

- Bite: A wound, bruise, cut or indentation in the skin caused by seizing, piercing or cutting skin with teeth.
- Bruise: An injury resulting from bleeding within the skin where the skin is discolored but not broken.
- Cut: An opening, incision or break in the skin made by some external agent.
- Dislocation: Displacement of any body part, especially the temporary displacement of a bone from its normal position in a joint.
- Munchausen's Syndrome by Proxy or Factitious Disorder: A form of child abuse in which a parent induces real or apparent symptoms of a disease in a child.
- Oral Injury: Injuries to the mouth, including broken teeth from a willful act.
- Puncture: An opening in the skin which is relatively small as compared to the depth, as produced by a narrow, pointed object.
- Welt: An elevation on the skin that can be produced by a lash or blow. The skin is not broken, and the mark is reversible.

Examples of Maltreatment:

- Pushing a child's head against the wall
- Punching a child in the stomach with or without a visible injury
- A parent biting his/her child
- Forcing a bottle into a newborn's mouth, breaking the frenulum
- Punching a child in the mouth, causing extraction of teeth
- Forcefully kicking a child, particularly in the abdomen, thoracic, cranial, or renal areas of the body.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- Is the physical injury on a high-risk (i.e., particularly susceptible to serious injury) body area, such as the head, neck, stomach, genitals or chest?
- Are there multiple injuries that appear to have been inflicted at various time intervals based upon stage of healing? Detail each (color, type, size, location, etc.).
- Are there injuries that appear to have occurred at approximately the same time or from the same incident but on different body planes (both back and front of body, both sides of the face or head, etc.)?
- Does the injury appear to be the result of a non-accidental, willful act by a caregiver?
- Is the explanation of the injury and mechanism consistent with the type and severity of the injury?
- Does the child have a medical condition, disability, behavioral, emotional problem or other issue that increases the child's vulnerability?

- Does the child or any eyewitness describe actions by the caregiver(s) that were so severe or out-of-control that the actions may have resulted in significant impairment regardless of injuries?
- Does the child have a significant injury suspected to be caused by abuse, regardless of the child's willingness to say how the injury occurred?
- Did the injury require emergency medical treatment?
- Was an instrument used during the incident? Detail.
- Are there patterns of similar incidents with this child or other children the caregiver has been responsible for?
- Does the injury appear to be a friction "burn" or abrasion from a rug, rope or from dragging? Describe to determine if there was willful intent by the caregiver responsible.
- Does the information present as an intentional act of aggression/anger by the caregiver or as an accidental/no intent/playful act by a caregiver (not maltreatment)?
- Are there injuries involving broken teeth? Does the information present as an intentional act of aggression/anger? Caregiver action or failure to act? (Assess any other maltreatment type, if failure to act is applicable.)

Frequently Associated Maltreatments:

- For "Physical Injury" due to neglect, assess for the appropriate neglect maltreatment.
- If a child is bitten by another child or animal, assess for "Inadequate Supervision."
- When a deadly weapon was accessible to a child, assess for "Environmental Hazards" or "Inadequate Supervision."
- If a caregiver threatens to use a deadly weapon against a child but does not have the weapon at the time of the threat, assess for "Mental Injury," "Household Violence Threatens Child," and "Intimate Partner Violence Threatens Child."
- If a caregiver threatens to use a deadly weapon against a child or household member and has a weapon at the time of the threat, assess for "Mental Injury," "Household Violence Threatens Child," and "Intimate Partner Violence Threatens Child."

Excluding Factors:

- Do not use this maltreatment for allegations other than abuse; this maltreatment is only used for injuries or real, plausible threat of injury due to caregiver acts (not omission/failure to act) (e.g., caregiver swings a cast iron skillet at child's head, but does not hit the child or leave injuries – the dangerous willful act had a significant threat of probability).
- In the absence of physical injury or threat of a physical injury by a willful act, a foster parent using corporal punishment on a child is a licensing or regulatory issue, not a "Physical Injury" maltreatment.
- "Nursemaid's Elbow" is a common childhood injury and is not, in and of itself, an injury indicative of abuse. Assess for how the injury occurred to make a determination for acceptance of a report and to reach a maltreatment finding.

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that the child has been the victim of a willful act or real, plausible and significant threat that resulted in or, by the nature of the willful act, threatened to result in any physical injury or harm that causes or is likely to cause the child's physical, mental or emotional health to be significantly impaired. This can be shown through the following:

- Interview of the alleged child victim
- Interview of Alleged Perpetrator (coordinate with law enforcement, if involved)
- Interview of Household Members/Witnesses/Collaterals
- Analysis of and reports and interviews from law enforcement
- Assessment of the Child Protection Team
- Photographic evidence, if any physical injuries are present
- Determination of the circumstances surrounding the maltreatment
- Documentation of current or past injuries
- Documentation of the typology of the injury, including location and description
- Identification and possible etiology (hand, belt, electrical cord, etc.) based upon observation, interviews and medical input.

In cases where there are no injuries present but there is a credible threat to child safety that is likely to result in serious injury in the imminent future, the CPI will add Threatened Harm to the report and assess findings for that maltreatment.

Sexual Abuse
(Battery, Molestation, Exploitation)

Section 39.01(30)(b-d), F.S., and Section 39.01(69), F.S.

Definition:
Sexual abuse is sexual contact with a child by the parent(s), legal guardian(s) or caregiver(s).

Sexual Battery is conduct involving the oral, anal or vaginal penetration by, or union with, the sexual organ of a child; the forcing or allowing a child to perform oral, anal or vaginal penetration on another person; or the anal or vaginal penetration of another person by any object. This includes digital penetration, oral sex (cunnilingus, fellatio), coitus, and copulation.
Section 794.011(1)(h), F.S., and Section 39.01(69)(a-c), F.S.

Sexual Molestation is the intentional touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs, and buttocks, or the clothing covering them, of either the child or the perpetrator, except that this does not include:

- Any act which may reasonably be construed to be a normal caregiver responsibility, interaction with, or affection for a child; or
- Any act intended for a valid medical purpose. Section 39.01(69)(d), F.S.

Sexual Exploitation is any other sexual act intentionally perpetrated in the presence of a child, if such exposure or sexual act is for the purpose of sexual arousal or gratification, aggression, degradation, or other similar purpose.

Note: In cases of commercial sexual exploitation of a child, the Human Trafficking maltreatment should be selected instead of Sexual Exploitation.

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- If there is another adult in the home, does the reporter think this adult household member is able to protect the child?
- Describe the sexual activity or the explicit sexual material to which the child is/was exposed.
- Describe how, when and where the parent/legal guardian or caregiver exposed the child to sexual activity or explicit sexual material.
- Describe how the caregiver failed to take actions to prevent the child from observing the sexual activity or explicit sexual materials.
- Is the child being used for the adult parent/legal guardian/caregiver's sexual arousal, advantage or profit?
- Does the child have a sexually transmitted infection? (Generally, children under the age of 10 are presumed to be less sexually active and less exposed to persons outside the household environment.)
- Did the caregiver(s) expose his/her sexual organs to a child in a way that is inappropriate or appears to be for sexual gratification?
- Has one child in the home been sexually abused by the caregiver(s)? Are there siblings in the home who may also be victims?

- Did the caregiver(s) sexually abuse a child? Does the caregiver who sexually abused a child also have other children living in the household who are the same sex and of similar age or physical development to the original child victim?
- What is the extent of the other caregiver's knowledge of the situation, including whether the other caregiver was present or also actively participating?
- Is there prior sexual abuse history involving the child or the caregiver(s)?

Frequently Associated Maltreatments:

- Assess for "Failure To Protect" when a child has been sexually abused in the past and the caregiver(s) allows the abuser to have contact unless court-ordered to do so or the abuser successfully completed treatment and the child's therapeutic intervention has approved contact.
- Also assess for "Mental Injury" when the child is showing significant emotional injury as a result of the sexual abuse.
- Also assess for "Physical Injury" if the sexual abuse has also resulted in any physical injuries to the child.
- Assess for "Medical Neglect" if the child is/was in need of medical care as a result of the Sexual Abuse and the child did not receive treatment due to caregiver negligence or refusal.

Excluding Factors:

- Normal caregiver(s) interaction and affection does not constitute "Sexual Abuse."
- Touching that is intended for valid home medical remediation or other professional medical purposes does not constitute "Sexual Abuse."

Assessing a Maltreatment Findings

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that a parent/legal guardian engaged in sexual contact (Sexual Battery, Sexual Molestation and/or Sexual Exploitation) with the child. This can be shown through the following:

- Interview of the alleged child victim
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Analysis of law enforcement reports and interviews
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team (Mandatory Referral)
- Documentation of an arrest made related to the sexual abuse incident
- Documentation of physical evidence observed by the CPI, law enforcement, medical professionals or the Child Protection Team
- Results of any psychological exams of the child and/or the caregiver(s)
- Documentation from prior history of sexual abuse in this family or by the caregiver(s) with different child victims, including prior allegations of sexual abuse made by the child
- In the vast majority of sexual abuse incidents, there is no physical injury or evidence of sexual activity. The history provided is often the only corroborating evidence.

Substance-Exposed Newborn

Definition:
Substance-exposed newborn as a maltreatment occurs when a child is exposed to a controlled substance or alcohol prenatally. Exposure to a controlled substance or alcohol prenatally is established by:

- A test, administered at birth, which indicates that the child's blood, urine or meconium contained any amount of alcohol or a controlled substance or metabolites of such substances, the presence of which was not the result of medical treatment administered to the mother or the newborn infant;
- A diagnosis of Neonatal Abstinence Syndrome or Fetal Alcohol Spectrum Disorder as a result of maternal use of a controlled substance or alcohol; or
- Knowledge or suspicion by medical personnel or hospital staff that an infant was exposed to a controlled substance or alcohol prenatally based on physiological or neurobehavioral abnormalities (e.g., seizures, muscle tightness, rapid breathing), and/or the mother's reported use of controlled substances or alcohol prenatally when such use would likely result in neonatal toxicology or withdrawal.

As used in this paragraph, the term "controlled substance" means prescription drugs not prescribed for the parent or not administered as prescribed, and controlled substances as outlined in Schedule I or Schedule II as defined in Section 893.03, F.S.

Examples of Substance-Exposed Newborns:

- A newborn exhibits withdrawal symptoms because of the mother's use of non-prescribed opioid medication during pregnancy.
- A newborn is treated for Neonatal Abstinence Syndrome due to the mother's abuse of methadone during pregnancy. The mother admits to taking a higher dose of methadone than was prescribed to her.
- A mother gives birth to a premature infant as a result of a placental rupture believed to be related to illicit drug use.
- A newborn's urine toxicology screen is positive for a controlled substance that was not prescribed during the mother's pregnancy or administered at the hospital.
- A newborn appears healthy and has a negative urine toxicology screen at birth; however, the mother is alleged to continuously abuse drugs and/or alcohol before and during her pregnancy. The child's meconium toxicology screen is pending, but it is suspected that it will be positive based on the mother's extensive substance use disorder.
- A mother is disheveled and under the influence of alcohol or other substances when she arrives at the hospital to give birth.

Assessing for Maltreatment

Factors to consider in Assessment of maltreatment

- Has the newborn and/or mother been tested for substances at birth, and what were the results? If the drug is a prescription drug, was the drug prescribed to the mother during pregnancy and used as prescribed?

- Has a physician diagnosed or noted withdrawal symptoms or other adverse effects?
- What is the reported history of drug or alcohol use, including any admission of use by the mother, and/or the extent of use during pregnancy? What type of drug was used and when was the last use?
- Has the mother's overall functioning declined over time relative to her drug use? Does she spend less time interacting with her children? Is she no longer employed? Medical complications related to drug use (ER visits, Marchman or Baker Acted, etc.)?
- Does the newborn's mother understand how substance abuse may cause direct harm to her baby?
- Has the mother ever received drug treatment? If yes, establish pattern of treatment.
- Do others in the home use drugs? Is the father aware of the mother's drug use during pregnancy? Does the father use substances as well?
- What are the medical and physical conditions of the child?
- What is the newborn's birth weight, gestational age, and APGAR scores? (This could be used to show correlation and draw inference to support adverse impact to an infant from parental substance misuse).

NOTE: If a child/and or mother tests negative for controlled substances or alcohol at birth, a thorough assessment of known or reported history of substance abuse during the pregnancy, including duration, frequency, pattern, and severity, should be completed to determine if there is sufficient information to support the acceptance of a report.

Frequently associated maltreatments
If a parent/caregiver's ongoing use of a controlled substance or alcohol has resulted in harm or a threat of harm to a child, also assess for "Substance Misuse (Alcohol, Illicit Drugs, Prescription Drugs).
If a parent/caregiver purposely gives a child poison, alcohol, non-prescribed drugs, or other substances that could result in adverse functioning, sickness, or internal injury, assess for "Substance Misuse."
If a parent/caregiver leaves poison, alcohol, medications, or other harmful substances readily accessible to a child, assess for "Inadequate Supervision."

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding
In order to verify this maltreatment, the preponderance of credible evidence will establish that a parent/legal guardian has exposed a newborn child to substances and, as a result, the child's physical, mental, or emotional health has been demonstrably adversely affected by the parent's drug or alcohol use. This can be shown through the following:

- Interview of the Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team
- Documentation of toxicology results and drug screens results for the child, caregiver(s), or both. However, the **results of drugs screens should not be the sole basis for the determination of maltreatment.** This should include a thorough assessment of known or reported history of substance abuse during the pregnancy, including duration, frequency, pattern, and severity.
- Assessment of pre-natal medical records
- Documentation, if any, of meconium drug testing results of newborns potentially exposed to drugs in utero

- Documentation of the adverse effect on the child related to a caregiver's substance misuse, such as complications related to premature birth, drug withdrawal at birth that may require detoxification for the child, etc.
- Documentation of inappropriate use/dose of prescribed medications, including a pill count, date of prescription, and directions for dosage
- Documentation from interviewing and/or observing the caregiver(s), children, and household members related to the extent of the caregiver's drug or alcohol use, focusing on the frequency and level of the use during pregnancy
- Documentation of decreased adult functioning correlated with the drug use
- Documentation of prior history of maltreatment linked to substance misuse in the family
- Documentation of drug-related criminal history
- Documentation of "Doctor Shopping" by the caregiver during pregnancy
- Analysis of reports and interviews from Law Enforcement

Substance Misuse

Section 39.01(30)(a)(2), F.S.

Definition:
Substance Misuse is purposely giving or administering a child poison, alcohol, drugs or other substances that substantially affect the child's behavior, motor coordination or judgment, or that result in sickness or internal injury.

Examples:

- A parent buying or giving his teenage child beer or alcohol while at home, causing the child to become intoxicated
- A parent giving her child marijuana or methamphetamine or smoking marijuana or methamphetamine with her child
- A parent purposefully giving his child bleach or antifreeze to drink in order to make the child ill
- Giving a child who is not prescribed ADHD medication another child's ADHD medication.
- Blowing marijuana or methamphetamine smoke directly into a child's face
- Giving a child ant poison to "kill the ants" because the child ate ants while playing outside

Assessing for Maltreatment

Factors to Consider in Assessment of Maltreatment:

- If there is another adult in the home, does the reporter think this adult household member has sufficient parental protective capacities to protect the child? Why or why not?
- What substances were consumed by the child and in what quantity?
- Did the caregiver(s) encourage and contribute to the child's drug or alcohol use?
- Why were the drugs or alcohol provided to the child? Were they for a religious ceremony or holiday tradition (e.g., at dinner or while dining)?
- Did the caregiver(s) give or cause poison, alcohol, drugs or other substances to be given to the child?
- Was the ingested poison a result of a willful act by a caregiver?

Frequently Associated Maltreatments:

- Assess for "Inadequate Supervision" if the lack of supervision or omission caused a child to be poisoned.

Excluding Factors:

- If a caregiver is administering prescribed or over-the-counter medication as recommended or prescribed by a medical provider, it is not "Substance Misuse."

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that a parent/caregiver has purposely given a child alcohol, illicit drugs, prescription drugs, poison or another substance and, as a result, the child's behavior, motor coordination, or judgment has been substantially affected, or sickness or an internal injury has resulted. This can be shown through:

- Interview of the alleged child victim
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team
- Documentation of inappropriate use/dose of prescribed medications, including a pill count, date of prescription, and directions for dosage
- Documentation from interviewing and/or observing the caregiver(s), children and household members related to the extent of the caregiver's drug or alcohol use, focusing on the frequency and level of the usage and the effects on the child
- Documentation of drug-related criminal history
- Documentation that the child has consumed poison, alcohol, drugs or other substances from witnesses and interviews or from medical results as a result of a parent/legal guardian/caregiver purposely giving such to the child and that the poison, alcohol, drugs, or other substances substantially affected the child's behavior, motor coordination or judgment or resulted in sickness or internal injury to a child

Substance Misuse

(Alcohol, Illicit Drugs, Prescription Drugs)

Section 39.01(3)(g), F.S., and Section 39.01(75), F.S.

Definition:
Substance Misuse is when a parent exposes a child to a controlled substance or alcohol. Exposure to a controlled substance or alcohol is established by:

- Evidence of extensive, abusive, and chronic use of a controlled substance or alcohol by a parent when the child is demonstrably adversely affected by such usage (e.g., filthy living conditions, poor parent-child interaction due to caregiver intoxication); or
- Knowledge or suspicion that a parent's ongoing use of a controlled substance or alcohol has resulted in harm or a threat of harm to a child, with special consideration given to the vulnerability of children age 0-12 months at the time of the report.

As used in this paragraph, the term "controlled substance" means prescription drugs not prescribed for the parent or not administered as prescribed, and controlled substances as outlined in Schedule I or Schedule II as defined in Section 893.03, F.S.

Examples:

- A child's physical appearance has deteriorated due to the parents abusing substances. The child does not have clean clothes, her body is dirty, and she has to fend for herself when making meals. She often does not get enough to eat because the parents have traded their food stamps for money for drugs.
- A mother who frequently consumes drugs or alcohol and is choosing to breastfeed the child, thereby exposing and providing the child with drugs through the breastmilk.
- A parent of a six-month-old infant has an extensive history of abusing alcohol or drugs and there are indications that the parent has started using again, resulting in a threat of harm to the child.
- A parent of an infant is alleged to be overusing a prescribed medication, causing the parent to "nod off" while caring for the infant.
- The parents frequently "disappear" for days at a time in order to use cocaine, leaving their 10-month-old child at the grandparents' home. The parents do not make arrangements prior to dropping the child off, and the grandparents have no way of contacting the parents or knowing when they will return.

Assessing for Maltreatment

Factors to consider in Assessment of maltreatment

- If there is another adult in the home, does the reporter think this household member has sufficient parental protective capacities? Why or why not?
- What type of drug(s) is the parent using? If the type of drug is unknown, what behavioral effects indicate that the parent is using drugs?
- Threats to a child of a parent who becomes sedated and inattentive after drinking excessively differ from the threats posed by a parent who exhibits aggressive side effects from methamphetamine use. Dangers may be posed not only from the use of illegal drugs, but also, and increasingly, from abuse of prescription drugs (pain relievers, anti-anxiety medicines, and sleeping pills).

- Danger may be posed by parents with a history of substance use disorders who are using unsafe sleep practices.
- What are the specific adverse effects to the child's safety, health, development, medical needs, education needs, well-being, supervision, protection or care as a result of parental substance misuse?
- What is the frequency and extent of the parent's alcohol or drug use (pattern, duration, incapacitation, threat to child safety, etc.)?
- Where is the child when the caregiver(s) uses drugs or alcohol/shortly after the caregiver(s) uses drugs or alcohol?
- What is the degree of behavioral or cognitive dysfunction or physical impairment linked to the caregiver's drug or alcohol use? What behaviors/indicators are observed related to the caregiver's drug or alcohol use?
- Has the parent's drug or alcohol use resulted in inadequate food, clothing, shelter, medical care, or supervision for a child? Has the parent's drug or alcohol use resulted in the death of a child?
- What is the reported history of drug or alcohol use, including any admission of use by the parent or caregiver, chronicity, frequency, duration, type of drug, and the extent of use (recent and historical)? What type of drug was used and when was the last use?
- Does the caregiver's admitted or observed history of drug and/or alcohol use cause concern about the caregiver's current ability to provide safe care for children under his/her supervision?
- Is it being reported that the caregiver was intoxicated or under the influence of a controlled substance while driving with a child in his/her vehicle?
- For individuals reportedly taking medication for chronic pain, is there a demonstrated improvement in their day-to-day functioning (improved work, relationships, interaction with children, etc.) since the medication was started, or has their functioning deteriorated or worsened?
- Can the child describe drug ingestion activities of the parent/caregiver, such as a route of administration (intravenous injection, snorting, smoking, etc.)?
- Can the child describe drug manufacturing techniques or equipment?

<u>For reports with a child age 0-12 months with substance misuse allegations</u>:

- What are the specific adverse effects to the infant's safety or care as a result of the parent(s)' substance misuse? If specific adverse effects are unknown, what adverse effects <u>could</u> occur based on the vulnerability of the infant and the parent(s)' ongoing use of substances?
- Are both parents abusing drugs and/or alcohol? If not, is the non-maltreating parent aware of the other parent's drug and/or alcohol use?
- Does the parent(s) understand how substance abuse may affect their ability to provide safe and adequate care for an infant?
- What type of drug(s) is the parent using? If the type of drug is unknown, what behavioral effects indicate that the parent is using drugs?
- Does the parent(s)' admitted or observed history of substance misuse cause concern about the parent(s)' suspected current substance misuse and/or their current ability to provide safe care for an infant?
- Have there been any significant changes in familial relationships and/or informal connections? These changes are often reported from the parent as family issues for no reason; however, further exploration can indicate that family has concerns about the parent's substance use that has caused negative relationships.

Frequently associated maltreatments

- Also, assess for "Environmental Hazards" when there are allegations of drugs being sold or manufactured from the home.
- Also, assess for "Inadequate Supervision" if a parent/caregiver leaves poison, alcohol, medications, or other harmful substances readily accessible to a child, or when a parent's substance abuse has influenced their ability to provide adequate supervision to the child.
- Assess for "Substance Misuse" if a parent/caregiver purposely gives a child poison, alcohol, non-prescribed drugs, or other harmful substances.

Excluding Factors

- An allegation that a parent is using/abusing substances without information supporting that the child's physical, mental, or emotional health has been adversely impaired or is in danger of being adversely impaired (e.g., based on the age/vulnerability of the child) is not "Substance Misuse."

Assessing for Maltreatment Finding

Information Necessary to Support a Verified Finding

In order to verify this maltreatment, the preponderance of credible evidence will establish that a parent/legal guardian has exposed a child to substances and, as a result, the child's physical, mental, or emotional health has been demonstrably adversely affected by the parent's drug or alcohol use. This can be shown through the following:

- Interview of the alleged child victim
- Interview of the Parents/Legal Guardians/Alleged Perpetrator
- Interview of Household Members/Witnesses/Collaterals
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team
- Documentation of toxicology results and drug screens results for the caregiver(s); however, the **results of drug screens should not be the sole determination of maltreatment.** This should include a thorough assessment of known or reported history of substance abuse, including duration, frequency, pattern, and severity.
- Documentation of the adverse effect on the child related to a caregiver's substance misuse, such as unsanitary living conditions
- Documentation of inappropriate use/dose of prescribed medications, including a pill count, date of prescription, and directions for dosage
- Documentation that the caregiver was responsible for the child at the time of or shortly following the drug or alcohol use and how the use of the substance impaired the caregiver's functioning
- Documentation from interviewing and/or observing the caregiver(s), children, and household members related to the extent of the caregiver's drug or alcohol use, focusing on the frequency and level of the use and the effects on the child; and behavioral indicators such as interactions, bonding, protective capacities
- Documentation of prior history of maltreatment linked to substance misuse in the family
- Documentation of drug-related criminal history
- Documentation of "Doctor Shopping" by the caregiver
- Analysis of reports and interviews from Law Enforcement

Threatened Harm

Definition:
Threatened harm is a behavior that is not accidental and which is likely to result in physical, emotional or mental harm or impairment to the child.

The Hotline is limited to the following situations for selecting this maltreatment:

- Death of a sibling or another child in the household as a result of child abuse or neglect provides reason to suspect that another child is in present or impending danger, or that child's safety is, or is reasonably likely to be, seriously threatened.
- An individual currently has children in out-of-home care or has had his or her parental rights involuntarily terminated, and has a new child or becomes a household member in a home where there are children present, and the reporter describes the caregiver as having diminished or limited parental protective capacities.
    - Out-of-home care means the placement of a child in licensed and non-licensed settings arranged and supervised by the Department or a contracted service provider.

Child Protective Investigators may add "Threatened Harm" to an open investigation if there are no injuries to support a defined maltreatment type, but there is a credible evidence, based on the caregiver's acts or failure to act, to indicate a real, plausible and significant threat to child safety.

Factors to Consider in Assessment of Maltreatment:

- What is the specific harm that is likely to occur? What family conditions are out-of-control? What is the potential for severe injury (sexual, physical, emotional, etc.)?
- If there is another adult in the home, does the reporter think this adult household member has sufficient parental protective capacities to protect the child? Why or why not?
- What is the connection of the actual incident to the likelihood of injury or future injury to each specific child?
- Is there prior documented abuse, neglect or child welfare history?
- Does the child have a medical condition; behavioral, mental, or emotional problem; or disability or handicap that impacts his/her ability to protect himself/herself, or behavior that significantly increases the stress level of the parent(s)/caregiver(s)?
- Is there a reported pattern of similar instances with this child or other children for whom the parent(s)/caregiver(s) has been responsible?

Excluding Factors:

- If the reporter is the **Case Manager** on an open case of a child where the mother or father has other children in out-of-home care and there are **no new** allegations of abuse, abandonment, or neglect, do not accept a report of "Threatened Harm" (e.g., parents continue to use drugs, home continues to be filthy, ongoing state of being). The case manager should be encouraged to evaluate the safety plan for sufficiency to manage safety in the home and to evaluate the case plan for appropriateness of service and level of services needed to ameliorate the ongoing condition or issue.)

Assessing for Maltreatment

Information Necessary to Support a Verified Finding:
In order to verify this maltreatment, the preponderance of credible evidence will establish that there is a credible threat to child safety that is likely to result in serious injury in the imminent future. This can be shown by the following:

- Interview of the alleged child victim
- Interview of Household Members/Witnesses/Collaterals
- Analysis of reports and interviews from law enforcement
- Interview of Parents/Legal Guardians/Alleged Perpetrator
- Prior history with the family related to the current maltreatment and family conditions
- Assessment of the Child Protection Team
- Documentation from interviewing prior or current investigators, case managers or staff within the Department, Community-Based Care lead agency, sheriff's office or other law enforcement officers who have knowledge of the family's circumstance, prior child welfare history, child functioning, adult functioning, and parental protective capacities
- Results of any psychological exams related to the caregiver(s)
- Information obtained from all medical records and professionals, including the Child Protection Team.

Special Conditions Referrals

The following pages contain information regarding the four special condition referrals. They are structured differently, since **no investigation is warranted or required and should not be expected.**

Special Conditions Referrals are requests brought to the attention of the Department that require a response by the Department, the investigating Sheriff CPI or Child Welfare Professional. These requests **do not** meet the criteria for a report of abuse, abandonment or neglect, therefore, no investigation should commence. These are social service responses aimed at linking families with community services, if requested.

Some of these referrals may result in the need to extend protection and shelter a child upon response.

If a child welfare professional responder conducting the assessment of a special conditions referral discovers information that constitutes reasonable cause to suspect that a child has been abused, abandoned or neglected, a report must be made to the Hotline. The Hotline personnel will evaluate the information provided and determine if reported concerns meet the criteria for child abuse, neglect or abandonment, thereby warranting a child protective investigation.

Caregiver(s) Unavailable

Definition:
Caregiver(s) unavailable is a situation in which a child is in need of supervision and care, but there is no parent, legal custodian or responsible adult caregiver immediately known and available to provide supervision and care, and there are no allegations that meet the criteria for a report of abuse, abandonment or neglect.

Examples of Caregiver Unavailable:

- Caregiver has been incarcerated, hospitalized, or died, and immediate plans must be made for the children's care
- Child is unable or unwilling to provide information about his/her parent, caregiver(s) or custodian
- A child is ready for discharge from a DJJ Intake Facility and the parents are not available to pick up the child.

Assessing for Special Conditions

Factors to Consider in Assessment:

- Is a caregiver available to make acceptable temporary living arrangements for the child? (What necessitates the need for or request for Department involvement?)
- Is law enforcement refusing to release the child to anyone until a Department person makes contact?
- How long is the parent/caregiver(s) expected to be unavailable to care for the child?
- Is a caregiver about to be incarcerated and plans must be made for the child's immediate care? Why is the caregiver being arrested? What is the barrier to the parent identifying a caregiver available to respond and take physical custody of the child?
- Is the caregiver about to be hospitalized and plans must be made for the child's immediate care? What is the barrier to that parent identifying an available caregiver to respond and take physical custody of the child?
- Have the caregivers died and plans must be made for the child's immediate care?

Excluding Factors:

- When the counselor identifies allegations of abuse, abandonment or neglect during the call that may or may not be related to the reason that the caregiver(s) is unavailable, an intake report will be accepted for response and assessment.

Child-on-Child Sexual Abuse

Section 39.01(7), F.S.

Definition:
Child-on-Child Sexual Abuse is any sexual behavior by a child (17 years and under), to another child, which occurs without consent, without equality, or as a result of coercion. For purposes of this subsection, the following definitions apply:

(a) **"Coercion"** means the exploitation of authority or the use of bribes, threats of force, or intimidation to gain cooperation or compliance.
(b) **"Equality"** means two participants operating with the same level of power in a relationship, neither being controlled nor coerced by the other.
(c) **"Consent"** means an agreement, including all of the following:
1. Understanding what is proposed based on age, maturity, developmental level, functioning, and experience.
2. Knowledge of societal standards for what is being proposed.
3. Awareness of potential consequences and alternatives.
4. Assumption that agreement or disagreement will be accepted equally.
5. Voluntary decision.
6. Mental competence.

Examples of Child-on-Child Sexual Abuse:
Juvenile sexual behavior ranges from noncontact sexual behavior, such as making obscene phone calls, exhibitionism, voyeurism, and the showing or taking of lewd photographs, to varying degrees of direct sexual contact, such as frottage, fondling, digital penetration, rape, fellatio, cunnilingus, penile penetration, oral sex, anal sex, sodomy, and various other sexually aggressive acts.

Assessing for Special Conditions

Factors to Consider in Assessment:

- Assess the specific behaviors of the child who has exhibited sexual behavior by means of coercion, inequality or without consent, and assess the specific behavior of the other child involved.
- Did the alleged event occur without consent, without equality, or as a result of coercion? Provide explanation.
- Consider the difference in age or developmental level between the child who exhibited sexual behavior by means of coercion, inequality or without consent and the other child involved.
- Are the parents aware of the sexual contact, and do they have concerns related to consent, equality or coercion?
- Have the children engaged in sexting? Have those images been shared publicly?

Frequently Associated Maltreatments:

- Fully assess for maltreatment, such as "Inadequate Supervision." A child-on-child sexual abuse referral may be accepted for response and assessment even when maltreatments are accepted for investigation.
- Assess for a "Parent Needs Assistance" referral if the information is not accepted as a child-on-child sexual abuse referral, there are no maltreatments identified, and the parent is requesting assistance with his/her child's sexualized behavior.

Excluding Factors:

- Regardless of the decision to accept a child-on-child referral for Department response, the counselor shall refer the caller to the local sheriff's agency to report the allegations.

Foster Care Referral

Definition:
Foster Care Referrals are reports to the Hotline regarding concerns about the care provided in an agency-licensed foster home, group home or emergency shelter that do not meet the criteria for acceptance of a report of abuse, abandonment or neglect. These are generally licensing or regulatory infractions or complaints.

Examples:

- A foster parent is observed obscenely yelling at a teenage foster child.
- Corporal punishment by a foster parent that does not leave an injury and would not likely leave an injury.
- The foster home is dirty but does not rise to the level of a maltreatment type of “Environmental Hazards.”

Assessing for Special Conditions

Factors to Consider in Assessment:

- Is the home/facility a licensed foster home, group home or emergency shelter?
- Does the information being reported appear to be a licensing or regulatory violation or generalized complaint about the foster parents or home?

Parent Needs Assistance

Definition:
Parent Needs Assistance referrals are calls received from a parent or legal custodian seeking assistance for himself or herself which does not meet the statutory criteria for an abuse, abandonment or neglect investigation. These calls may be accepted by the Hotline for response to prevent or ameliorate a potential future threat of harm to a child. If it is determined by a child welfare professional that a need for community assistance or services exists (food, diapers, utilities, etc.), the Department or other contracted child welfare professional shall refer the parent or legal custodian for appropriate voluntary community services. Also, if the parent wants the child removed from the home because the child is disobeying, running away, disrespectful, etc., the parent may be expressing anxiety and dread about his/her ability to control his/her emotions and reactions toward the child. This expression represents a "call for help" or a parent needing assistance.

Examples of Parent Needs Assistance:

- Parents/legal custodian state they will maltreat or fear they will mistreat without assistance.
- Parents/legal custodian describe conditions and situations which stimulate them or could provoke them to think about maltreating.
- Parent/legal custodian talks about being worried about, fearful of or preoccupied with maltreating the child.
- Parent/legal custodian identifies things that the child does that aggravate or annoy the parent/caregiver in ways that make the parent want to lash out/strike the child.
- Parents/legal custodians anticipate situations in which the parent(s) or legal custodian(s) will be incarcerated or hospitalized and request assistance with plans to be made for the children's care.

Assessing for Special Conditions

Factors to Consider in Assessment:
Presumably, a caregiver in need of assistance recognizes that his or her reaction to the situation/circumstances could become serious and could result in severe effects on a vulnerable child. The admission or expressed anxiety is sufficient to conclude that the caregiver might react toward the child at any time, and assistance from the Department is sought to ameliorate the concern.

- What assistance have the parents/legal custodians asked for in order to be able to care for the child, such as counseling, medical, residential placement, psychiatric assessment or assistance from the school or law enforcement?
- Is there anyone with whom the parents or legal custodians could allow the child to live temporarily, such as relatives or family friends, while the family obtains assistance?
- Have the parents/legal custodians considered professional placement, such as teen shelter, safe haven, or residential facility? Assist with linking the parent/legal custodian to external resources as a resolution.
- Are the parents/legal custodians willing to work with DCF or a contracted provider to assist them to make arrangements for the child?
- Does it sound like a situation that could get worse and quickly escalate to child abuse, neglect or abandonment if the family does not get assistance?
- Would the family benefit from general services offered in the local community (e.g., diapers, utility assistance, food, child care, etc.)?
    - Provide 2-1-1 or other contact information to the caller, transfer call to the local community-based care lead agency and refer to the community-based care lead agency for services.

Chapter 11

SUBSTANCE ABUSE CONSULTATIONS

11-1. Purpose. For purposes of child protection assessment and interventions, it is important to accurately identify substance abuse disorders in order to determine child safety and inform parents of the comprehensive array of services available to achieve or maintain recovery.

a. Out-of-control conditions in substance abusing families can be particularly challenging for investigators to assess because family and individual dynamics, such as denial and co-dependency issues, minimize if not outright deny that alcohol or substance misuse are problematic or are active in the family.

b. These aspects associated with the dynamics of addiction emphasize the need for the investigator to consult with substance abuse professionals in order to assist in an accurate assessment and identification of any substance misuse or dependency problem.

11-2. Procedures.

a. When information available at pre-commencement or obtained during the family functioning assessment indicates that substance misuse is believed to be occurring in the home the child protective investigator must consult with a substance abuse expert in order to:

(1) Assess whether the substance misuse is out of control to the point of having a direct and imminent effect on child safety.

(a) Identify specific harm(s) to the child caused by or highly correlated with the substance abuse.

(b) Provide input on what safety actions need to be incorporated into a safety plan for children of substance abusing parents to control the direct and imminent effects of the parent or caregiver's substance misuse or relapse event.

(2) Review the user's current use pattern (to the degree known or reported), prior treatment history and outcomes from prior intervention efforts to explore the most likely and appropriate treatment options (e.g., need for medical detox, intensive outpatient, etc.). Explore the potential use of the Marchman Act to the family in order to assess the harmful effects of the substance misuse to the user and to control for the imminent and direct effects of the parent/caregiver's active substance abuse for child safety. This includes educating and informing family members on the process of petitioning the court for an involuntary assessment (and possibly treatment and stabilization order) of the substance abusing family member.

(3) For individuals in recovery who deny active use, explore the patterns of behaviors typically indicative of a pending relapse, including but not limited to:

(a) Dishonesty;

(b) Irresponsibility;

(c) Depression, anxiety and sleeplessness;

(d) Unreasonable resentments;

(e) Isolation from others; and,

(f) A pattern of non-compliance (if a safety or case plan is in place).

(4) Explore the feasibility of the substance abuse expert accompanying the investigator to the interview site when available, based upon local protocols and working agreements.

b. The investigator will thoroughly assess family dynamics looking for behaviors and patterns of interaction indicative of co-dependency.

(1) m“Parentified child.”

(2) Over/Under functioning between user and co-dependent partner.

c. The investigator will also seek mental health expertise when there are concerns that a co-occurring mental health condition is present in order to ensure that services for both conditions are provided at the same time, to avoid triggering the symptoms of the co-occurring condition that is not being addressed.

11-3. Supervisor. When initiated, supervisor consultations are provided to affirm:

a. The investigator is successfully achieving collaboration and teamwork with professionals during the safety assessment to assess for substance abuse.

b. The investigator’s understanding and adherence to local protocols.

11-4. Documentation.

a. The investigator will document the information provided to substance abuse professionals to assist in the assessment process and the recommendations resulting from the consultation activities in a case note within two business days.

b. The supervisor will document the supervisor consultation, if conducted, in FSFN using the supervisor consultation page hyperlink in the investigation module within two business days.

CHAPTER IX. John H. Chafee Foster Care Independence Program (CHCIP) and Education and Training Vouchers (ETV)

The Chafee Foster Care Independence Program (CFCIP) and Educational Training Vouchers (ETV) are in place to help ensure that youth and young adults who are involved in, or who have aged out of, the foster care system have access to the tools they need to develop the necessary skills to make a successful transition towards self-sufficiency. Florida continues to provide an array of services to current and former foster care youth, designed to assist youth in their journey toward independence.

Currently the Florida Department of Children and Families provides services, supervision, and case management to an estimated 4,565 youth between the ages of 13 and 17 who are residing in out-of-home care. Approximately 1,604 of those youth are residing in relative and non-relative out-of-home care settings. All youth in foster care are provided opportunities to engage in age or developmentally appropriate activities to ensure they master independent living skills. Additionally, there were an estimated 960 youth who turned 18 while in out-of-home care, 149 youth age 16 and older who were adopted, and 322 youth age 16 and older whose cases were closed with guardianship in State Fiscal Year (SFY) 2015-2016. Those youth and young adults are potentially eligible to receive independent living services and supports based on their former foster youth status.

The Florida Department of Children and Families, through CBC lead agencies (see Chapter III), offers a wide array of services and direct support payments to current and former foster care youth that are designed to promote the acquisition of general life skills, educational and employment attainment, maintenance of housing, and development of permanent connections. All CBC contracts include requirements to administer all services in accordance with federal guidelines, Florida Statutes, and Florida Administrative Code. Florida has highly structured statutory requirements for Extended Foster Care (EFC), Post-Secondary Education Services and Supports (PESS), Road to Independence (RTI), and aftercare services around establishing client eligibility, standards of progress, payment disbursement, and payment amounts, as well as due process and appeals. Requirements in Florida Administrative Code further detail the framework for how the array of independent living services is administered, including application and discharge procedures, transition planning, and documentation requirements.

Programmatic and Oversight Requirements

Florida codified all programmatic and general oversight requirements associated with the John H. Chafee Foster Care and Independence Program (CFCIP) program within Florida Statue. Florida has detailed and structured statutory requirements that establish the Independent Living programs, client eligibility requirements, payment calculations, payment disbursement requirements, payment amounts, as well as rights of a client to appeal a denial or termination of services. Each of the following sections of Florida Statute address requirements associated with required services and delivery of these services to current and former foster care youth:

- Section 39.013, F.S., Procedures and jurisdiction; right to counsel
- Section 39.4091, F.S., Participation in childhood activities
- Section 39.6035, F.S., Transition plan
- Section 39.6251, F.S., Continuing care for young adults

- Section 39.701, F.S., Judicial review
- Section 409.145, F.S., Care of children; quality parenting; "reasonable and prudent parent" standard
- Section 409.1451, F.S., The Road-to-Independence Program
- Section 409.1452, F.S., Collaboration with Board of Governors, Florida College System, and Department of Education to assist children and young adults who have been or are in foster care
- Section 409.1454, F.S., Keys to Independence Act

Description of the program approach based on the legislation is included in the remainder of this chapter. Extended Foster Care requirements are included in s. 39.6251, F.S., continuing care for young adults. Postsecondary Education Services and Support for young adults, as well as aftercare services, are included in s. 409.1451, F.S., the Road-to-Independence Program, which includes some elements of the previous Road-to-Independence program prior to Florida's redesign of independent living services in 2014. Specifically, youth age 18-22 who had been receiving services prior to the effective date of this legislation have been grandfathered into the prior Road to Independence Program. This grandfathered program is clarified and detailed by Florida Administrative Code in force until replaced (65C-31 F.A.C., Services to Young Adults Formerly in the Custody of the Department). Refer to updates and accomplishments in Chapter II, Florida Administrative Code for details. Programmatic changes in support of revised statutory requirements began upon the effective date.

Requirements Related to Case Management and Caregiver Activities and Judicial Oversight

Section 409.145, Florida Statute (F.S.), requires that all life skills training for current foster care youth ages 13 through 17 be identified and developed by the child, case manager and the child's foster parent or group home provider utilizing a collaborative case management approach to develop an individualized plan. Identified needs are documented and the training associated with the needed life skill is conducted via an "in-the-home" training model that is delivered by the child's caregiver. This approach is designed to create a more normal and organic format for the development and acquisition of necessary life skills in comparison to more traditional classroom and test based life skills acquisition programs.

Section 409.145(2), F.S., establishes requirements that caregivers (foster parents and group home providers[15]) participate in all case planning activities, including life skills development, and that caregivers ensure that all children in their care between the ages of 13 and 17 learn and master independent living skills. Per s. 39.701 (2)(a)10., F. S., a written report must be provided to the court at each judicial review hearing that includes a statement from the caregiver detailing what progress the child has made in acquiring independent living skills. This caregiver statement is required for all foster care children who have received life skill training after the ages 13 years of age but who are not yet 18 years of age.

Section 39.4091, F.S., empowers caregivers to make decisions and use a reasonable and prudent parent standard when considering age-appropriate extracurricular, enrichment, and social activities for the children in their care. Liability for harm has been removed for caregivers using this standard, weighing

[15] Per 409.145(3), F.S. "Caregiver" includes a person with whom the child is placed in out-of-home care or a designated official of a licensed group care facility. In the Department's system of care, "out-of-home care" usually includes both licensed care such as family foster homes and residential group homes, and unlicensed care such as relative/kinship.

potential risk factors and acting in the best interest of the child. The Department and community-based care lead agencies, along with their subcontracted agencies providing out-of-home care services are to promote and protect children's ability to develop through normal childhood activities.

Section 39.6035, F.S., requires development of specific transition plans for youth who are going to age out of the foster care system. Transition plans are developed in collaboration with the child and caregiver and any other individual whom the child would like to include. These plans may be as detailed as the child chooses. The plans are designed to supplement standard case planning activities and are subject to court review. The activities addressed within these plans must provide specific options for the child to use in obtaining specific services and required items that must be covered by the plan include issues associated with housing, health insurance, educational attainment, and workforce support and employment services. The plan must also consider establishing and maintaining naturally occurring mentoring relationships and other personal support services. This transition plan must also include the required discussion about health care decisions and offer the ability to the child of creating a health care surrogacy document (as required by the Fostering Connections Act).

Section 39.701(3) (a) 4, F.S., requires a judicial review within 90 days after the 17th birthday of a youth in out-of-home care. At that review, a report must be submitted to the court detailing what steps have been taken to inform the teen of independent living programs and services. Section 39.701(3) (d) 4, F.S., requires that independent living service eligibility be addressed for a second time at the last judicial review prior to the young adult reaching the age of 18 and the child affirms that they understand they are aware of their service eligibility and how to apply for services should they choose to do so.

Young adults who at the age of 18 were residing in licensed foster care placement have the option to enter Florida's non-Title IV-E funded Extended Foster Care (EFC) program. Section 39.6251, F.S., details the initial eligibility, continuation of services, case management standards and program exit and reentry requirements. Section 39.701(4), F.S., contains the judicial oversight requirements that require the engagement of young adults in case planning and life skill development. Young adults who have chosen to reside in extended foster care are required to have their case reviewed by the court a minimum of once every 6 months.

For Postsecondary Education Services and Support (PESS), under the Road to Independence program, requirements associated with eligibility, application for aid, agreements, disbursement of payments, renewal, and appeal or denial of postsecondary educational stipend payments are established within s. 409.1451(2), F.S. This section further provides stipend amounts, including for various categories of participant that the amount is equivalent to the basic foster care room and board rate defined in s. 409.145, F.S., is negotiated, or is a flat monthly rate provided in statute. Room and board in this context is defined in the Department's financial system as "Deposits for housing and utilities; Safe housing; sufficient food to meet the young adult's nutritional requirements; and utilities, including electricity, gas, water, and garbage collection." [16] Section 409.1451(3), F.S., defines eligibility and assistance for aftercare services.

Section 409.1452, F.S., establishes requirements that the Department collaborate with the Florida Board of Governors, the Florida College System, and the Florida Department of Education to establish academic

[16] Chart 8 System, OCAs for PESS, including EFPES

support systems. These systems provide a comprehensive support structure that help assist children and young adults who choose to attend college with the opportunity for successful transition from the foster care system to a publicly supported postsecondary educational program.

Section 409.1454, F.S., establishes a statewide pilot program to pay specified costs of driver education, licensure and costs incidental to licensure, and motor vehicle insurance for a child in licensed care between the ages of 15 to 21 who meets certain criteria. A driver's license can help a youth obtain employment, go to school events, and participate in social activities. However, there are many barriers for youth in foster care who want to learn to drive safely and to obtain a driver's license. The pilot project reimburses youth and caregivers for costs associated with driver's education, obtaining driver's licenses, and motor vehicle insurance.

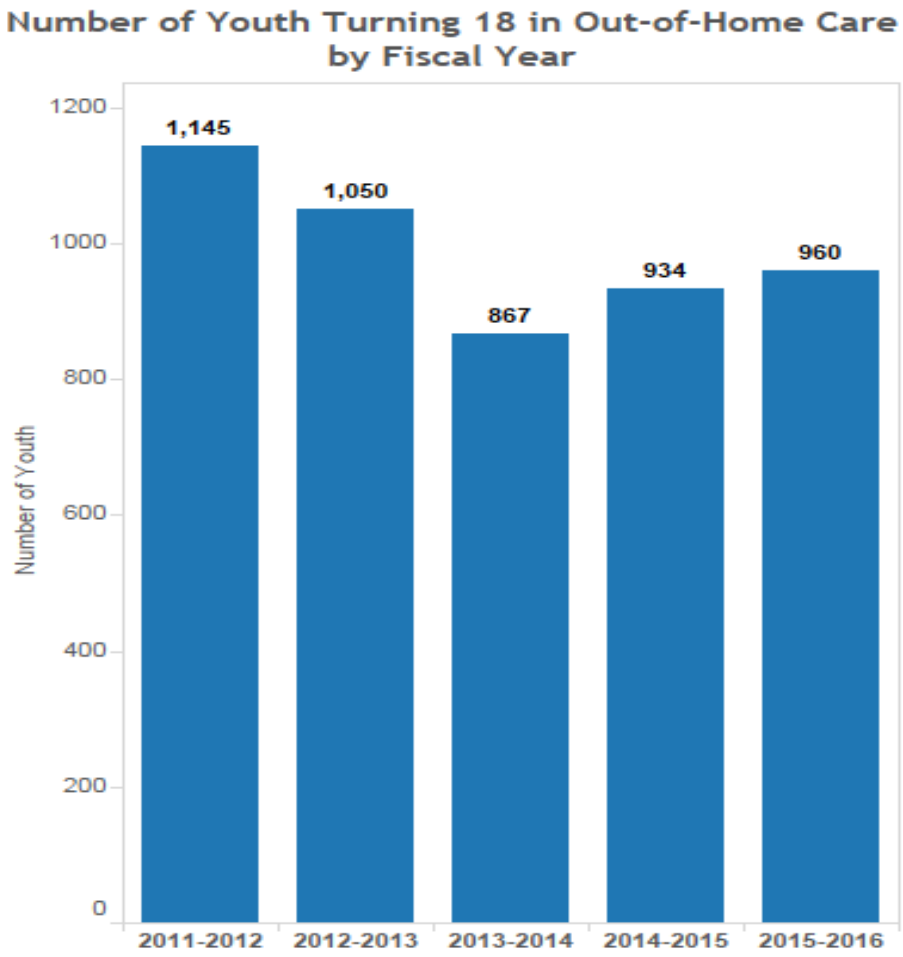
Delivery of Services for Youth and Former Foster Care Young Adults

As described in Chapter I, the Department contracts with Community-based Care (CBC) lead agencies that have administrative responsibility for all Independent Living services and receive the relevant funding per contract. The CBC with case management responsibility for a child who aged out of the foster care system, was adopted, or was placed into a permanent guardianship retains responsibility for the young adult regardless of where the child moves within the state. However, should a young adult who resides out of the area serviced by the CBC require assistance, the CBC having care responsibility must contact the CBC where the child currently resides.

CBCs are able to access technical assistance related to programmatic and financial activities through the Department's Office of Child Welfare and the lead agency Fiscal Accountability Unit. The Department also monitors overall CBC performance related to the delivery and administration of Chafee Foster Care Independence Program (CFCIP) services through the Contract Oversight Unit. The structure of Florida's statutory and regulatory requirements have helped the state develop an array of independent living services that engages a large number of current and former foster care youth.

Youth Exiting Out-of-Home Care at age 18

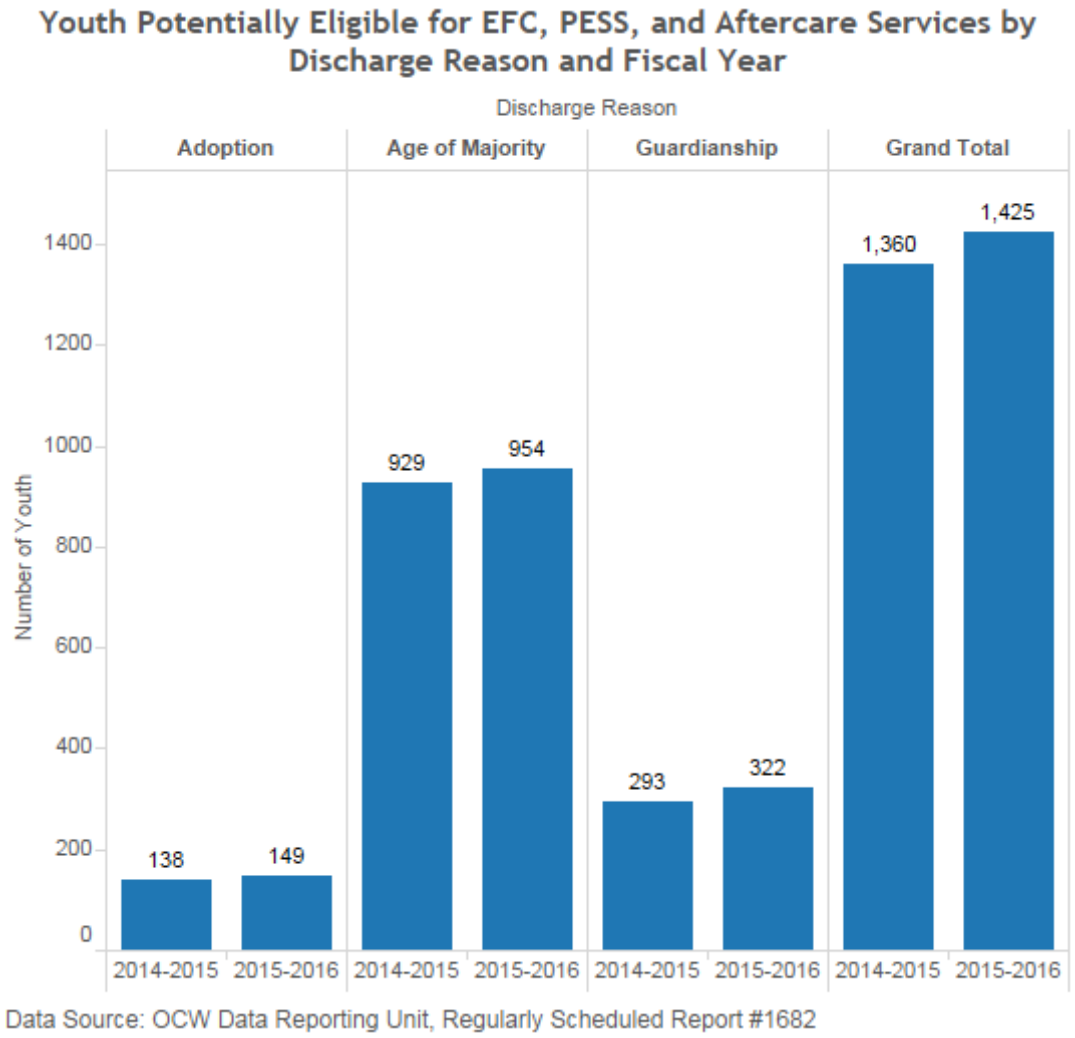
The chart below depicts five years of data by State Fiscal Year (SFY). The charts includes 18-year-olds who have aged out of foster care, without taking into account the status of legal custody or their placement type at the time of discharge.. As shown, the number of young adults exiting out-of-home care at 18 had been declining since 2011 but began increasing in 2014. In SFY 2015-2016, 26 more youth exited out-of-home care than in SFY 2014-2015.



Source: Child Welfare Services Trend Report

Youth Potentially Eligible for Independent Living Services

The chart below depicts the number of youth ages 16, 17, and 18 who are or will be potentially eligible for EFC, PESS, or aftercare services by discharge reason. Since each program is unique in its eligibility, young adults may be eligible for one program but not the other. In SFY 2015-2016, 65 more youth were potentially eligible for services compared to SFY 2014-2015. Each discharge category showed an increase in youth.



Extended Foster Care (EFC)

In support of the development of more permanent bonds for Florida's former care youth, s. 39.6251, F.S., requires the Department to develop and implement EFC for youth between the ages of 18-21 (up to age 22 for youth with disabilities). The program does not utilize Title IV-E funds but instead uses a combination of CFCIP funds and state funds. One of the key components of the program that young

adults who wish to stay in the foster care system should have their current placement viewed as the preferred placement for the young adult. Should the young adult's current placement not be available or practical, it is the responsibility of the CBC service provider and the young adult to identify an alternative placement that may, or may not be licensed and that offers a degree of supervision to best meet the immediate and long-term needs of the young adult.

Standard case manager visitation, case planning activities, life skills training, and judicial reviews are also required. To maintain eligibility for participation in the program young adults must be:

- Enrolled in secondary education;
- Enrolled in an institution that provides postsecondary or vocational education;
- Participating in a program or activity designed to promote or eliminate barriers to employment;
- Employed for at least 80 hours per month; or
- Unable to participate in programs or activities listed above on a full time basis due to a physical, intellectual, emotional, or psychiatric condition that limits participation.

By offering young adults the option to enter extended foster care, it is believed that the development of necessary permanent connections, will be more available to Florida's former foster care youth. Currently over 1,200 young adults have elected to remain in foster care while they work in partnership with their CBCs to achieve independence. In addition, the formation of an extended care methodology has emerged to identify how to care for young adults beyond age 18. The direct care providers in collaboration with the caregiver have embarked on providing a more collaborative living environment that takes into consideration the "level of care and agreements" that should exist when a young adult resides in a natural parenting situation. This has led to the development of housing agreements and roommate agreements with clearly defined goals of transition and appropriate adult behavior. These agreements have provided direct care providers with the opportunity to assist young adults in utilizing skills such as positive relationship development, community resource utilization, and effective communication and conflict resolution.

Postsecondary Education Services and Support (PESS) (formerly Road to Independence Program)

Postsecondary Education Services and Support (PESS) replaced the former "Road to Independence" program (RTI), effective January 1, 2014. Young adults enrolled in eligible post-secondary institutions and who meet other eligibility criteria are eligible for this program. Florida has grandfathered young adults on the former Road to Independence (RTI) program, allowing them to remain eligible under the prior criteria until they complete the program or age out. Young adults grandfathered into the old RTI program have the right to apply for enrollment in any of the new programs.

Eligibility requirements include:

- young adults who turned 18 while residing in licensed care and who have spent a total of six months in licensed out-of-home care; or
- who were adopted after the age of 16 from foster care, or placed with a court-approved dependency guardian, after spending at least 6 months in licensed care within the 12 months immediately preceding such placement or adoption;

And

- who have earned a standard high school diploma, or its equivalent, and
- are enrolled in at least 9 credit hours and attending a Florida Bright Futures eligible educational institution.

If the young adult has a documented disability or is faced with another challenge or circumstance that would prevent full-time attendance and the educational institution approves, the young adult may be approved to attend fewer than nine credit hours.

Once eligibility is established, the young adult qualifies to receive a monthly stipend of $1,256. The disbursement process of the stipend is determined by the young adult and the CBC. In some cases, the youth may choose to have the service provider make all housing and utility payments directly to the housing or utility provider. Any remaining funds are to be disbursed to the young adult. This arrangement may continue until the young adult and the service provider have determined that the young adult has gained a certain level of money management skills. The eligibility requirement also requires the young adult to apply for financial aid through the Free Application for Federal Student Aid system. This methodology gives the service provider and the young adult the ability to develop communication strategies about budgeting, financial projections and navigating the college experience with a strong financial outlook.

The law limits PESS to Florida Bright Futures eligible schools. However, there is another, more limited financial support for a young adult who wishes to attend a post-secondary school that is not a Bright Futures school, e.g., an out-of-state school. An annual federal Educational Training Voucher (ETV) educational stipend payment of up to $5,000 may be available, provided the chosen academic institution meets ETV eligibility requirements and the young adults meets the other PESS requirements. Federal ETV payment amounts are set by a needs assessment that determines the student's total financial need, to ensure that federal ETV payments do not exceed a student's total cost of attendance. However, the monthly payment for PESS is fixed at $1,256 per month so any payments in excess of a student's estimated cost of attendance or the $5,000 federal ETV limit are covered by state funds. In addition, students remain eligible for participation in the program up to their 23rd birthday so students who apply or reenter the program after the age of 21 are required to have the entirety of their payments covered by state funds.

Students receiving the PESS post-secondary educational stipend may also opt into extended foster care. The method of the payment depends upon whether the young adult is residing in a foster home or group home or is temporarily residing away from the home.

Students must maintain a reasonable standard of academic progress in order to remain enrolled in this program. In the event that the young adult should fall below academic progress as defined by their postsecondary education institution, the young adult will be given a probationary period to maintain eligibility.

Prior experience and statistical evidence have shown that requiring young adults to maintain a standard full-time enrollment in postsecondary education can be detrimental to the completion of their education. Many of these young adults struggled to complete secondary education; others need to work to

supplement the financial assistance; and others are parenting one or more children. Florida defines as "full time" for this program as nine credit hours, providing additional flexibility for the young adults served, however, a young adult may enroll in additional credit hours. Any young adult with a recognized disability or who is faced with another challenge or circumstances that would prevent full-time attendance, i.e., nine credit hours or the vocational school equivalent, may continue receiving PESS provided the academic advisor approves the student's completion of fewer credit hours.

A student is eligible to remain in PESS, or to reenroll in PESS, at any time until the 23rd birthday. Participation in the program is approved on annually, based on the enrollment date of each individual.

In addition to the federal ETV and state aid packages listed above, Florida's public postsecondary institutions also offer Florida's former foster care youth a tuition and fee exemption, remaining valid up to the young adult's 28th birthday.

Aftercare Services

Aftercare services are temporary services and/or financial payments designed to prevent homelessness and to meet the immediate needs of young adults formerly in foster care. These services, including financial assistance, serve as a "bridge" between continuing care and full independence. A young adult is eligible to receive aftercare services if he or she was in a licensed placement on their 18th birthday and is not receiving either extended care, pursuant to s. 39.6521, F.S., or PESS, pursuant to s. 409.1451, F.S. In addition, a young adult still receiving old RTI program benefits may not receive these services.

- Aftercare services include, but are not limited to, the following:
    - Mentoring and tutoring
    - Mental health services and substance abuse counseling
    - Life skills classes, including credit management and preventative health activities
    - Parenting classes
    - Job skills training
    - Counselor consultations
    - Financial literacy skills training and
    - Temporary financial assistance for necessities, including but not limited to, education supplies, transportation expenses, security deposits for rent and utilities, furnishings, household good, and other basic living expenses.

Prior Road to Independence

Prior to January 1, 2014, young adults served in the Road to Independence program could attend secondary or postsecondary educational settings. This meant that some participants received non-ETV-funded educational stipend payments toward completion of secondary and GED educational programs. Young adults were required to provide proof and maintain full-time enrollment (part-time for students with a diagnosed disability) in an eligible secondary educational program. Award amounts were determined by an annual needs assessment (maximum allowable award $1,256 per month) and all awards were subject to annual review and renewal that required that the student submit an updated

needs assessment, provide documentation that they continued to be enrolled, and that their academic program considered them to making adequate academic progress.

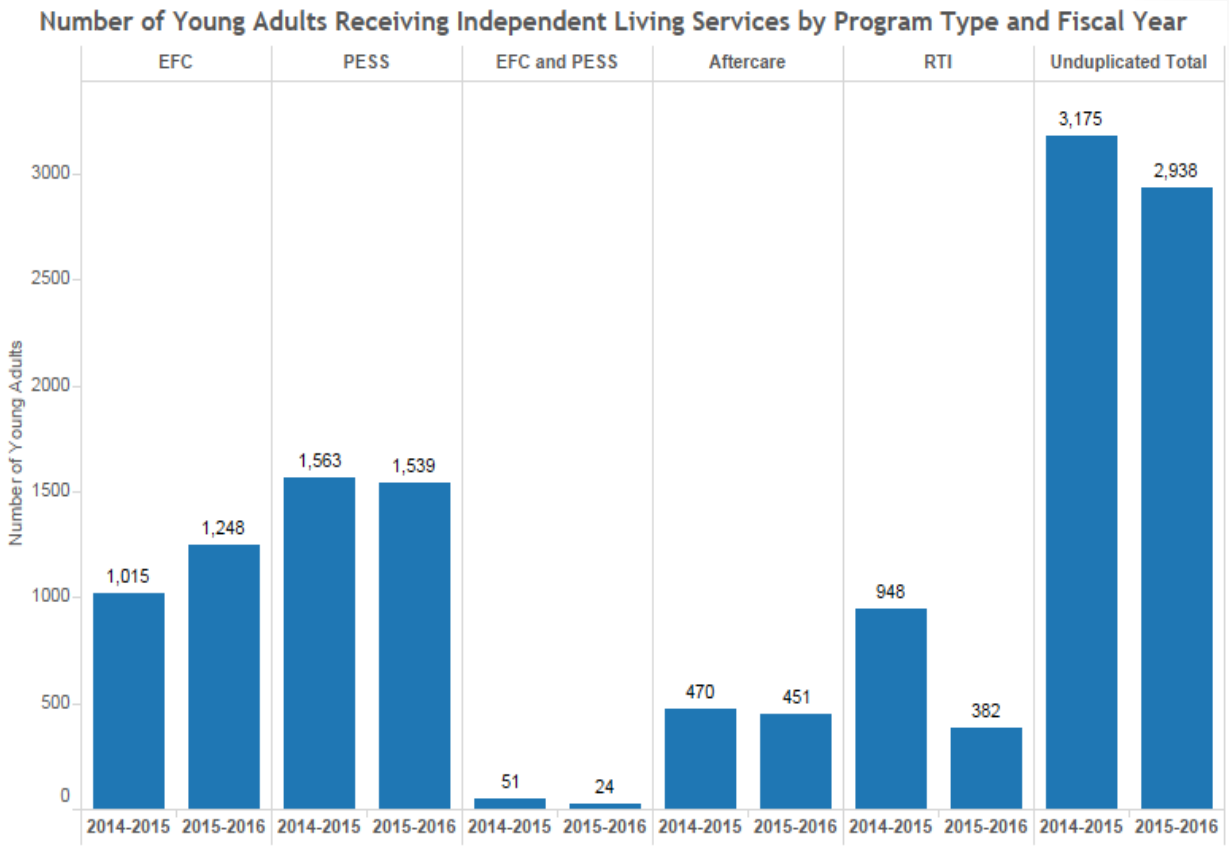
These supports are still available for young adults "grandfathered" after the implementation of legislation described above. However, this use of a direct payment program has been replaced by the "extended foster care" approach which requires youth aging out of licensed care to remain in continuing (or extended) care unless the youth opts out of this program. For youth who have not yet completed a secondary educational program, continuing care is the only post-18 program option.

By moving young adults away from a direct payment program associated with secondary school attendance toward that of more supportive living arrangements, the percentage of young adults formerly in foster care between the ages of 18 and 19 years of age completing secondary education should improve. In addition, it gives the case management provider the opportunity to work with the youth on preparing for independence. Young adults who entered the RTI program prior to January 1, 2014 are able to continue within the program as long as they maintain eligibility. Thus, a group of young adults could continue to receive services and payments though the old RTI until 2018.

The Road-to-Independence program has included postsecondary services and was Florida's ETV program for former foster care youth. As of January 1, 2014, no new RTI applications have been accepted. However, students who were participants in the program prior to January 1, 2014 may continue to participate in the program up to their 23rd birthday provided they maintain enrollment and adequate academic progress as defined by their postsecondary institution.

Young Adults Receiving Independent Living Services

The bar chart below illustrates the number of young adults who received an independent living service, by program, and in total, between the reporting periods. To be counted in this report, a young adult must have received an independent living service payment generated through Florida Safe Families Network (FSFN). The number of young adults served by EFC increased by 233 from SFY 2014-2015 to SFY 2015-2016. The number of young adults in PESS and Aftercare Services declined during this same time period. Some young adults may have received more than one service type in a particular year; therefore, a count reflecting an unduplicated total is also shown. Overall, there were 237 fewer young adults participating in independent living services in SFY 2015-2016 than in SFY 2014-2015.



Source: FSFN OCWDRU #1173

Financial Accountability

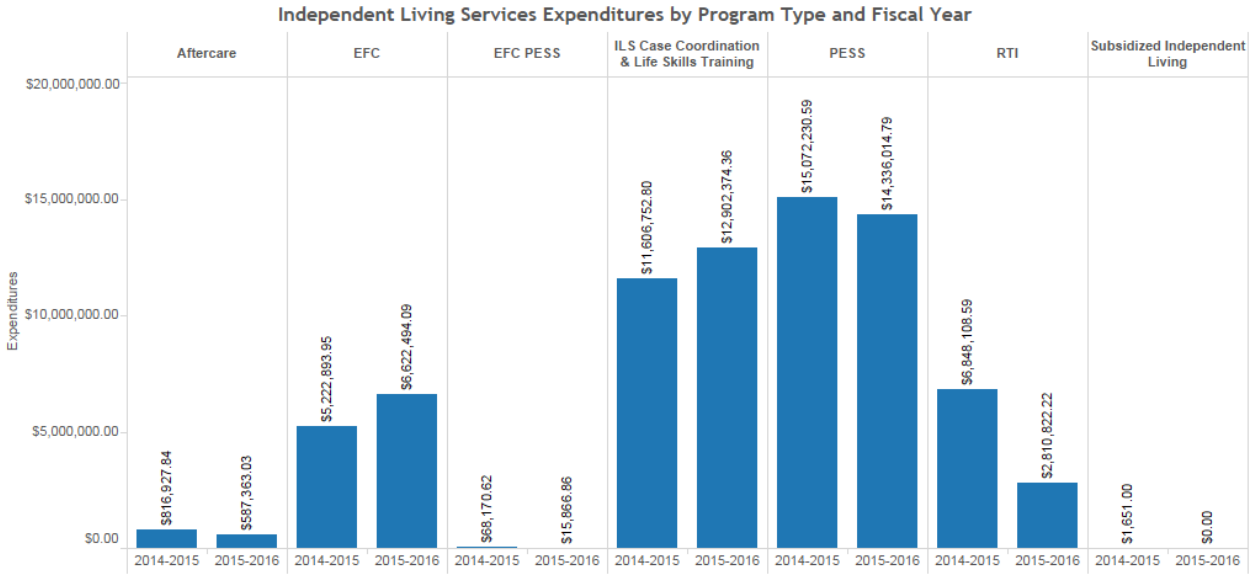
During the SFY 2015-2016, the Department's Office of CBC/ME Financial Accountability provided technical assistance and oversight to DCF contract managers and CBC financial staff throughout the state to ensure accurate recording of payments in FSFN. A monthly review of Independent living services payments occurred for the following:

- payment amounts adhere to the amounts pursuant to Florida Statutes and Florida Administrative Code;
- young adult's eligibility within each program is appropriately documented in FSFN; and
- federal and state funds are paid only to eligible young adults based on age for the program in which the young adults have been approved.

In addition to technical assistance, quarterly reviews were performed for selected payment records by each CBC to ensure correct application of financial requirements and payments were allowable. At the beginning of the SFY, each CBC was evaluated for its agency's financial accountability of the funds provided by the Department, including actual expenditures recorded for the prior SFY, any carry forward funds available, as well as the agency's submitted Cost Allocation Plan. The Cost Allocation Plan identifies

how the funds for each program will be spent during the year. As needed, any identified fiscal issues were discussed with the CBC and adjustments made accordingly.

The Florida Legislature appropriated $29,451,721 each SFY for independent living services. The total appropriation is to include the cost of the case management associated with the delivery of services to young adults as well as the supplemental room and board payment to foster care parents for providing independent life skills and normalcy supports to youth ages 13 through 17. The graph below displays the actual amount spent in each program by SFY. As detailed in the graph for SFY 2015-2016, total expenditures have exceeded the $29 million appropriated by over $7.8 million. (Note: Subsidized Independent Living Program ended January 2014.)



Source: DCF Chief Financial Officer Group, CBC YTD Actual Expenditures including Carry Forward for IL, EFC, RTI programs

Florida utilizes the Education and Training Vouchers (ETV) to support the educational success of young adults enrolled in PESS or those who meet the PESS requirements other than attendance at a Florida Bright Futures eligible institution that reside out of state. CBC lead agencies administer ETV funds. Florida currently utilizes ETV funds for programs that could also be funded using CFCIP and state funds. Both the availability and payment amount for ETV is contingent on the availability of funds.

Unduplicated Count of ETV Awards

State Fiscal Year	Count
2014-2015	1,208
2015-2016	1,163

Program Accountability

While the Department has made progress in data collection and contract monitoring, which assists in program oversight, identification of specific outcomes and benchmarks are needed for improved communication around expectations in program goals.

System-Driven Data

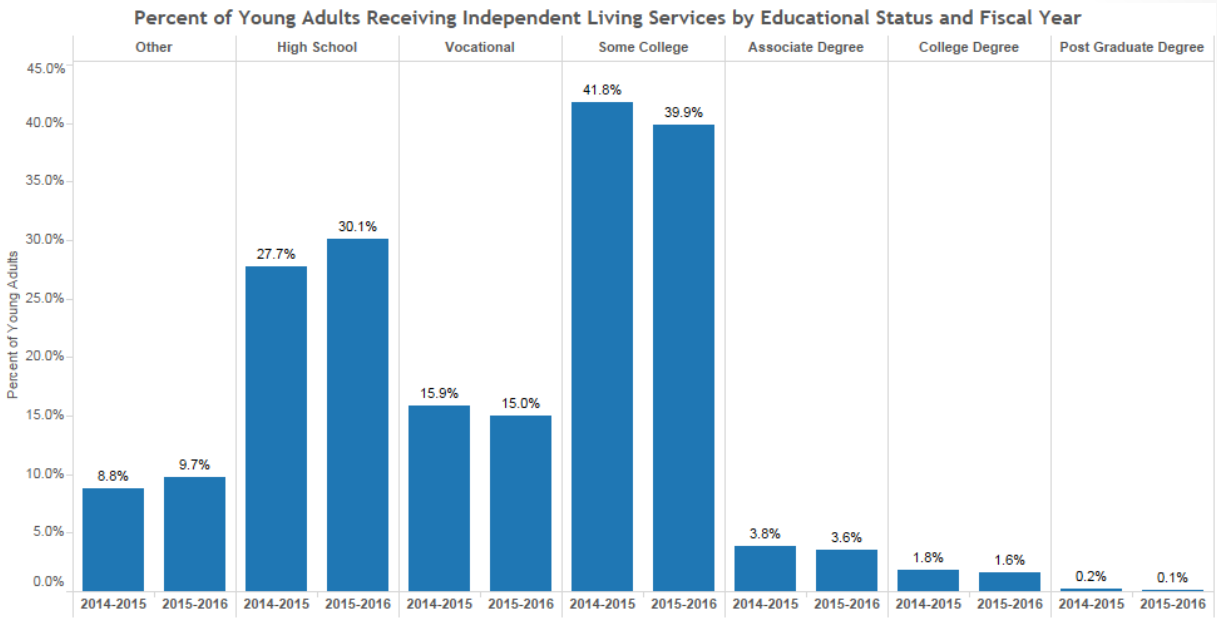
Florida Safe Families Network

The Department uses Florida Safe Families Network (FSFN), the statewide automated child welfare information system, to develop data reports to assist in ongoing analysis of gaps and trends. Gathering facts and statistics around Florida's youth and young adults participating in services are critical in determining program effectiveness and measuring outcomes. To maintain data accuracy, the Department and CBCs monitor relevant independent living services data elements by accessing On Demand reports in FSFN. The Office of Child Welfare Data Reporting Unit (OCWDRU) creates reports to assist in monitoring such focus areas as: education, employment, and housing. CBC staff responsible for managing independent living services complete data integrity checks. Additionally, the Department develops guidance for CBCs to utilize when completing data entry specific to youth in transition. Recognizing that accurate data entry is critical to accurate reporting, a recent revision to the National Youth in Transition Database (NYTD)-FSFN Desk Reference was distributed in September 2016 to all fiscal staff, case managers, independent living and other specialists. In the Desk Reference, an overview about the mandatory data collection system is provided, along with the purpose, a description of the population whose outcomes are being tracked, and a step by step guide on what information needs to go where in the system.

Education

Improving educational (academic or vocational) attainment is one outcome area that the Department monitors through FSFN system data. Although educational attainment is a goal for all independent living programs, PESS is the only service category that requires enrollment and academic progress as a condition for continued eligibility. EFC allows young adults to choose a qualifying activity other than attaining an education. Two of the five qualifying activities for eligibility in EFC require young adults to be enrolled in school.

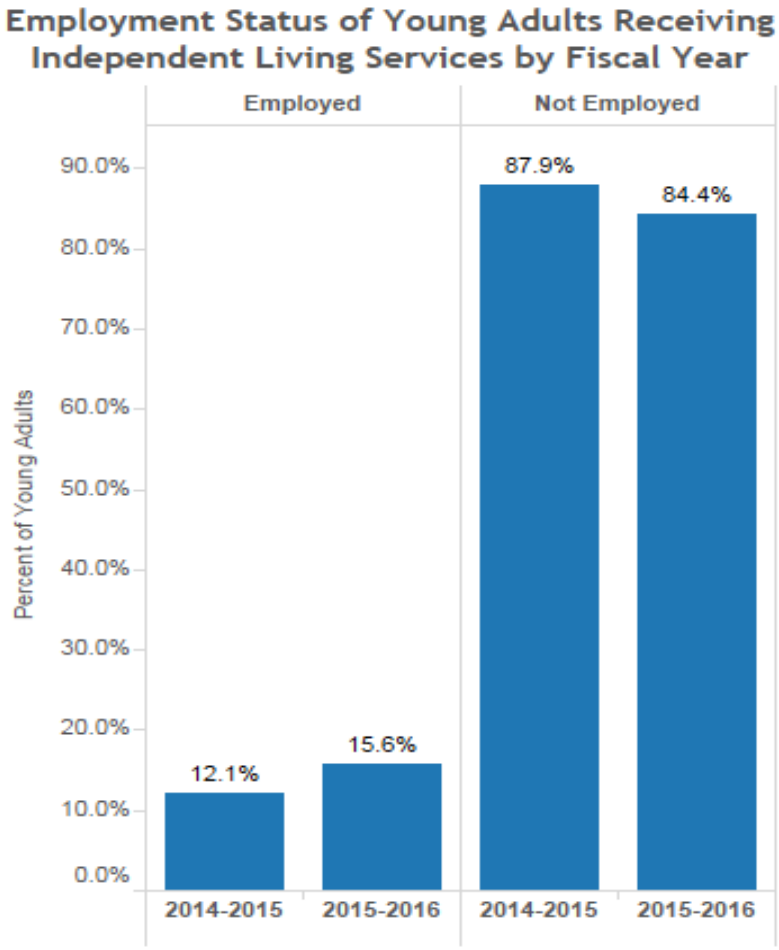
The chart on the next page illustrates the percentage of young adults who received funding for an independent living service and the young adult's highest recorded educational achievement during the reporting period. The "Other" category represents those young adults whose education entries reflected "None", "Not-Graded", "Not Applicable", "Special Education", or "Unknown". There was a 2.4% increase from SFY 2014-2015 to SFY 2015-2016 in young adults attaining high school diplomas; there was a 1.9% decrease in young adults with "some college" documented as their highest achievement.



Source: FSFN OCWDRU Report #1173

Employment

Increasing financial self-sufficiency is another outcome that the Department monitors through FSFN data. Financial self-sufficiency can be achieved by taking steps to create a stable income, building a savings account, and staying out of debt. Employment is one step toward increasing self-sufficiency and is a qualifying option for eligibility in EFC. The Department supports employment for all transitioning youth, and encourages employment and career opportunities as appropriate, based on the skills and abilities of each young adult.



Source: FSFN OCWDRU Report #1170

The chart to the left depicts the percentage of young adults who received an independent living payment and were either employed or not employed at some point during the applicable fiscal year. From SFY 2014-2015 to SFY 2015-2016, there was a 3.5% increase in young adults employed. (See Appendix E for CBC level data.)

Housing (Living Arrangements)

Reducing homelessness among youth is another outcome area that the Department monitors through FSFN. The Department and the CBCs strive to ensure that every young adult served has an appropriate living arrangement and the necessary supports needed for the young adult to become successful. EFC is the only service category that requires an assessment of the young adult's living environment as an eligibility factor. Assessment of each young adult's life skills and abilities helps CBC lead agencies determine what level of supervision is needed. FSFN currently offers 15 different living arrangement documentation options. Living arrangement categories range from "Own Housing" to "Assisted Living Facility" or "State Correctional Facility".

FSFN data from June 2015 to June 2016 (OCWDRU #1180 Count of Living Arrangement for Young Adults Receiving Independent Living Services) reflected an increase in supported housing type living

arrangements. More young adults were reportedly living in dorms, transitional living programs, host family homes, and group homes. Although supportive housing types are up, "Renting Housing" remains the most frequently reported living arrangement type. There was no reported change in young adults living in licensed foster homes.

Current and Former Foster Care Youth Surveys[17]

Florida's use of self-report questionnaires along with ongoing analysis of system-driven data assists with oversight and accountability of independent living services. The surveys are a tool to engage current and former foster care youth in providing necessary feedback for evaluation of program effectiveness. Responses may demonstrate how effectively statue, rule, policy, and case management activities have been implemented and whether those services meet the needs of our clients. Florida has worked diligently with contractor, Cby25® Initiative, Inc. (Cby25®) to develop a comprehensive survey system.

National Youth in Transition Database

The NYTD survey is administered each year by Cby25® to current and former foster youth in predetermined cohorts of 17, 19, and 21 years for data collection. The Department recognizes the significance of utilizing the longitudinal model for assessing how former foster youth are moving towards achieving the goal of adult self-sufficiency and accessing independent living services. This report year, the age 19 follow-up population were surveyed between October1, 2015 through September 30, 2016.**Florida**

NTYD Plus and My Services

In an effort to ensure that all 18-22 year olds receiving independent living services have a voice, Florida made the decision to have Cby25® administer a similar version of the federal survey. Florida NYTD Plus survey is administered on an annual basis to former foster youth. The survey can be completed on-line, on paper, or by telephone. Survey answers are private and each young adult has a unique log-in password that is issued by the Department. This survey was administered between April 15 and May 31, 2016. Over 1,200 young adults provided responses to questions related to transition planning, education, employment, housing, financial, transportation, connections, and health and well-being. A full report on the survey responses is located on the Department's website. CBC specific survey data is available through a DCF data portal link.

My Services is a 200+ question online survey that is administered by Cby25® at a minimum of annually that attempts to survey all youth (ages 13-17) in licensed care. The survey provides general information on how well teens are being prepared for adult self-sufficiency as well as how they view the overall quality of services provided by the foster care system. The survey period launched April 15 and ended May 31, 2016. Over 1,100 youth participated. Due to the length of the survey, youth are encouraged to complete the survey on-line in modules. Based on feedback from the past two survey administration periods, Florida has begun the process to streamline the survey. The goals for this upcoming year is to reduce the number of questions, engage more youth, and increase the rate of participation. In addition to the service delivery information learned from survey feedback, other aspects of service delivery are analyzed using the data available in FSFN. Currently, categories and questions covered by the survey include:

[17] Survey results are posted on the Department's internet site, http://www.myflfamilies.com/service-programs/independent-living/reports-and-surveys.

- Case management practices and general documentation requirements
- Educational attainment services and progression planning
- Employment preparation and employment supports
- Financial literacy training, Life skills training
- General foster care support and quality
- Ability to participate in normal teen activities
- Health/dental care service
- Involvement with the juvenile/criminal justice system
- Preparation for aging out of the foster care system

Sample Survey Results

The following survey responses are a sample of the over 200 questions that youth have an opportunity to answer in a number of categories. There has been an overall decline in survey participation over the past five years.

Normalcy

Source: My Services Survey - Responses by youth ranging in ages 13-17.

Youth ages 15-17 that have a learners permit	Year	Spring 2012	Spring 2013	Spring 2014	Spring 2015	Spring 2016
	Percentage Yes	10%	9%	12%	12%	14%
	Number Yes	117	88	97	99	101
	Total	**1,199**	**930**	**842**	**847**	**712**

Youth ages 16-17 that have a driver's license	Year	Spring 2012	Spring 2013	Spring 2014	Spring 2015	Spring 2016
	Percentage Yes	2%	3%	2%	5%	3%
	Number Yes	22	20	13	29	13
	Total	**862**	**687**	**591**	**582**	**470**

Court Hearings

Source: My Services Survey - Responses by youth ranging in ages 13-17.

Youth ages 13-17 that attend foster care court hearings (at least sometimes)	Year	Spring 2012	Spring 2013	Spring 2014	Spring 2015	Spring 2016
	Percentage Yes	75%	83%	81%	75%	74%
	Number Yes	1,288	1092	1020	973	814
	Total	**1,712**	**1,319**	**1,272**	**1,300**	**1102**

Transition Planning

Source: My Services Survey - Responses by youth ranging in ages 13-17.

Youth ages 17 that reported having signed an IL Transition Plan and that it was filed with the court	Year	Spring 2012	Spring 2013	Spring 2014	Spring 2015	Spring 2016
	Percentage Yes	76%	48%	43%	46%	37%
	Number Yes	211	184	110	130	88
	Total	**409**	**387**	**286**	**284**	**235**

Safe & Stable Housing

Source: FL NYTD-Responses by young adults age 18-22.

Reported having been homeless in the past	**Year**	**Florida NYTD 2012**	**Florida NYTD 2013**	**Florida NYTD 2014**	**Florida NYTD 2015**	**Florida NYTD 2016**
	Percentage Yes	28%	15%	31%	72%	22%
	Yes	492	261	421	786	248
	Total	**1,821**	**1,852**	**1,424**	**1,288**	**1,206**

Health & Well Being

Source: FL NYTD-Responses by young adults age 18-22.

	Year	Florida NYTD 2012	Florida NYTD 2013	Florida NYTD 2014	Florida NYTD 2015	Florida NYTD 2016
Received family planning counseling or services during the past two years	Percentage Yes	12%	7%	11%	7%	7%
	Yes	201	123	144	83	72
	Total	**1,821**	**1,852**	**1,424**	**1,288**	**1,206**

	Year	Florida NYTD 2012	Florida NYTD 2013	Florida NYTD 2014	Florida NYTD 2015	Florida NYTD 2016
Given birth or fathered any children	Percentage Yes	35%	27%	30%	26%	17%
	Yes	446	474	274	318	188
	Total	**1,821**	**1,852**	**1,424**	**1,288**	**1,206**

Collaboration, Committees, Workgroups, and Advocacy Groups

A strength that helps to drive youth participation and engagement is the state's strong connection with youth advocacy groups and organizations. Florida continues to engage with organizations that help to provide a voice to youth and make them aware of the needs of transitioning young adults. As youth transition to adulthood, there are many services and supports needed that are not within the scope of those provided through the child welfare system. Partnerships with other agencies are critical to the successful transition of our young adults. These partnerships focus on these five essential areas: education, employment, housing, health care and other support services.

Consultation with Tribes for CFCIP and ETV

Chafee and ETV funds are designated for current and former foster care youth as required by the Indian Child Welfare Act (ICWA). The Department is making every effort to ensure that children are placed within their tribal families and not in licensed foster care. (See Chapter V.) If tribal children do enter licensed foster care, they are entitled to any and all benefits and funding that any child, tribal or not, would be eligible to receive. In the Department's work with the Seminole and Miccosukee tribes, access to various forms of federal funding have been discussed and neither tribe has expressed an interest in receiving federal funds at this time as they have their own resources to provide services.

Florida's Quality Parenting Initiative and Life Skills Training and Academic Supports for Foster Youth

Florida's Quality Parenting Initiative (QPI) empowers Florida's foster care parents and group home providers to become more engaged in the child welfare planning and service delivery process. QPI is designed to help develop new strategies and practices, rather than imposing a predetermined set of "best practices". The core premise is that the primary goal of the child welfare system is to ensure that children have effective, loving parenting and that they live normal lives. The best way to achieve this goal is to enable the child's own parents to care for him or her. When this is not possible, the child welfare system must ensure that the foster, relative, or non-relative family caring for the child provides the loving, committed, skilled care that the child needs, while working effectively with the system to reach the child's long-term goals.

The key elements of the QPI process are:

- To define the expectations of caregivers;
- To clearly articulate these expectations; and then
- To align the system so that caregivers can meet the expectations.

Areas of the state that have implemented QPI principals have experienced improvement in outcomes such as:

- Reduced unplanned placement changes;
- Reduced use of group care;
- Reduced numbers of sibling separation: and
- More successful improvements in reunification.

Life skills and academic goals are created through collaboratively engaging the child, case manager, and caregiver in development plans that meet the near and long term goals of the child. Caregivers are required to engage the child in activities that will help foster the development of the needed life skills or academic supports and report the results of these efforts to the case manager. The case manager then consolidates this information, entering into FSFN for inclusion at the child's next judicial review.

The Department is dedicated to meeting the service needs for lesbian, gay, bisexual, transgender, and questing (LGBTQ) and transgender and gender-nonconforming (TGNC) youth in foster care. The Department has updated Florida Administrative Code for group care that will include guidance as it relates to caring for this population in a group setting. The Department's statewide 2016 Child Protection Summit provided a training workshop on gay–straight alliances in schools, community building and advocacy resources for LGBT youth, transgender youth in out-of-home care, and LGBT foster and adoption parenting. The training was presented to foster parents, relative guardians, adoptive parents, workers in group homes, Guardians ad Litem, judiciary, child protective investigators, licensing staff, and case managers regarding the challenges faced by these youth.

Florida Youth SHINE

Florida Youth SHINE continues to engage current and former youth in foster care across the state of Florida. Youth members receive leadership training/advocacy training and discuss areas needing improvement. Their advocacy spans from speaking directly to the Governor and legislature to providing education and training to the general public on the needs of foster youth. In 2016, the fourteen chapters held numerous meetings and participated in various events. The youth also partner with, or serve as representatives on, local Youth Advisory/Advocacy Boards. Additionally, 10 youth were selected from across the state to complete a digital storytelling project about their experiences in foster care, which was shared with the child welfare community on-line and in person at the Florida Department of Children and Families Child Protection Summit in September, 2016

The Florida Youth Leadership Academy

The Florida Youth Leadership Academy (FYLA) is a leadership development program for youth involved in the child welfare system. The 2016 leadership class was comprised of 16 youth from across the state, who received extensive communication, strategic sharing, and public speaking training throughout the course of the 10-month program while paired with an adult mentor. The goal is for youth to develop the skills necessary to be an employed, productive and independent adult, to include but not limited to: conflict resolution, advocacy, interpersonal, and relationship. The skills FYLA youth develop help them leverage their unique and challenging life experiences as they transition into adult members of our community. The program activities included camping, college tours, a visit to the State Capitol, and attending Peace Jam. The most recent class graduated at the Child Protection Summit in September of 2016. The 2017 leadership class was selected in December, 2016 and has 18 youth. The program sponsored by DCF is in its tenth year.

Florida Reach

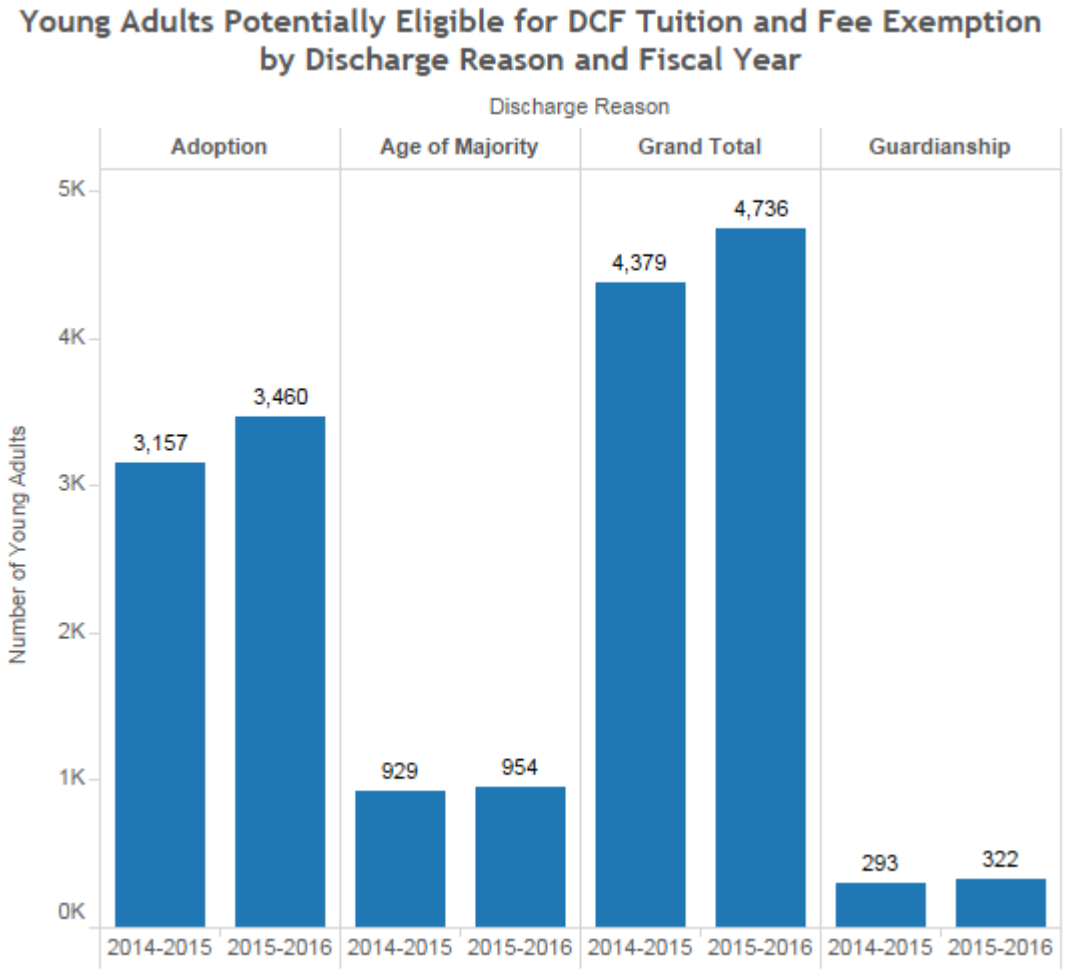
Without the attainment of a post-secondary degree or credentials, youth who age out of foster care face the realities of unemployment, homelessness and incarceration in their young adult years. In accordance with section 409.1452, Florida Statutes, the Department continually works in cooperation with the Board of Governors, Florida College System and Department of Education to establish and maintain dedicated foster care liaisons and campus coaching programs at all public colleges and universities. With the assistance of Florida Reach, a network of professionals dedicated to improving postsecondary outcomes for youth formerly in foster care, the campus coaching initiative remains a priority of the Department. In June 2016, the Department sponsored the third Annual Florida Reach Symposium in Miami. Miami Dade College and Florida International University hosted the event, which drew more than 140 individuals to workshops designed to expand the vision of campus-based support programs.

Additionally, Florida provides tuition and fee exemptions to eligible young adults, designed to support efforts to improve postsecondary outcomes. The exemption is authorized at Florida's public universities, colleges and school district workforce education programs. Fee exemptions are provided to students if:

- in the custody of the Department of Children and Families when reached age 18;
- adopted from the Department of Children and Families after May 5, 1997;
- at the time of reaching age 18 is in the custody of a relative under s. 39.5085, F.S.;
- at the time of reaching age 18 is in the custody of a non-relative under s.39.5085, F.S.; or,

- placed in a guardianship by the court after spending at least 6 months in the custody of the Department after reaching 16 years of age.

The following chart displays the number of youth potentially eligible for the DCF Tuition and Fee Exemption by discharge reason and fiscal year. Young adults are eligible to continue to receive the exemption until the age of 28. Of the potentially eligible population for SFY 2015-2016, those youth discharged to adoption are the largest population with 3,460 youth potentially eligible.



Data Source: OCW Data Reporting Unit, Regularly Scheduled Report #1682

Independent Living Services Advisory Council

The Department engages a wide range of state agencies through the Independent Living Services Advisory Council (ILSAC). ILSAC membership includes representatives from CBC lead agencies, Department of Education, Agency for Health Care Administration (AHCA), State Youth Advisory Board, Workforce Florida,

Inc., statewide Guardian ad Litem Office, foster parents, recipients of the Road-to-Independence Program funding, and other advocates for foster children.

The Independent Living Services Advisory Council (ILSAC) was created in 2002 by the Florida Legislature and is codified in s. 409.1451(7), F.S. ILSAC has the responsibility for reviewing and making recommendations concerning the implementation and operation of the independent living services for current and former foster care youth, including issues or barriers as well as successes. Each year the Advisory Council prepares and submits a report to the Florida legislature and the Department on the status and needs of services for current and former foster care youth statewide. In its annual report for 2015, ILSAC made several recommendations to the Department. The full annual report and the Department's response are exhibits to Chapter VIII, CAPTA as ILSAC is also one of the Department's designated citizen review panels for CAPTA purposes. Copies of annual reports and other information are located on the Department's Independent Living internet site, http://www.myflfamilies.com/service-programs/independent-living.

Florida Department of Children and Families – Economic Self Sufficiency - Health Care

DCF continues to improve former foster youth access to health care through the monitoring of Medicaid enrollment. Data matching efforts continue within the Department between Office of Child Welfare and Economic Self Sufficiency programs. The lists are matched and the information is then disseminated to the CBCs to follow up with those young adults who are currently eligible but not enrolled.

Additionally, Appendix C in the Child and Family Services Plan for 2015-2019 describes the connection between the Department's responsibilities for foster youth and the health care under the purview of the Agency for Health Care Administration (AHCA) in the section titled "Healthcare Transition Planning for Youth Aging Out of Foster Care."

Florida Department of Health -Teen Pregnancy Prevention

The Florida Department of Health, Adolescent Health Program administers the Title V State Abstinence Education Grant, from the U.S. Department of Health and Human Services, to fund local health departments and community based organizations to provide sexual risk avoidance education. This education focuses on promoting delayed sexual activity in order to avoid pregnancy, sexually transmitted diseases, and other consequences. The funded providers use evidence-based and effective abstinence education curriculums such as *Choosing the Best*, *Making A Difference*, *Promoting Health Among Teens*, *Real Essentials*, and *Heritage Keepers* to deliver the program. These curriculums encourage parent and significant adult involvement. All classes are delivered in school or community based settings.

The Adolescent Health Program currently funds ten local health departments and four community based providers in middle school, high school, and community settings. These providers began a new grant cycle in October of 2015 and will continue through September of 2019. Providers were selected through a Request for Applications process. Applications were reviewed for need, capacity, and thorough plans to reach adolescents age 11-19 with high rates of teen birth, repeat teen births, and sexually transmitted diseases. Through partnerships with these providers, the Adolescent Health Program will continue to work to improve the health of Florida adolescents through skill building, goal-setting, and providing sexual risk avoidance education.

Health Departments located in all 67 of Florida's counties serve adolescents, many providing services unique to youth, including streamlined paperwork, dedicated hours and entrances. Local community based care agencies also have working agreements with county health departments, allowing youth to access pregnancy prevention services and other services available to them. Another example is in the northeast region where Family Support Services of North Florida (FSS) coordinates with other local social service and health organizations the Teen Parenting Initiative for Children and Youth in the Child Welfare System. The purpose of the task force is to educate teens, parents/caregivers, and caseworkers about pregnancy and parenting, in order to prevent and reduce pregnancies and repeat pregnancies.

Florida Department of Agriculture and Consumer Services - Fostering Success Project: Employment

Fostering Success is a joint program between the Florida Department of Agriculture and Consumer Services (FDACS) and the Florida Department of Children and Families (DCF), which provides young adults, who are either currently or formerly in the foster care system, with an opportunity to gain professional work experience in a supportive environment. Through the Fostering Success Program, DCF administers employment readiness and professional life skills training, as well as job placement services within different state agencies. Each participant is given a part-time, paid position for a year, and attends team development events and monthly training workshops on a variety of topics which include: financial literacy; resume building and interview preparedness; communication techniques; networking; conflict resolution; mindfulness; and self-love and respect. The program has also provided its participants with additional services, such as transportation assistance (free bus passes), professional work attire, networking and volunteer opportunities, and food and housing assistance. The goal for next year is to find employment for at least 10 youth at FDACS, and begin a new partnership with Florida Fish and Wildlife Conservation Commission (FWC) to staff an additional 7 foster youth. Since the programs implementation, 2 youth have transitioned into full-time positions within their respective agencies.

Conclusion

The Department expects outcomes for young adults participating in independent living services to improve with continued strengthening of oversight, collaboration, and clearly communicated expectations. The Department's goal is to enhance independent living services delivery through a thorough and continuous examination of the cases, performance and fiscal data, as well as other reports received by the Department from stakeholders.

The Department will continue to work in partnerships with the CBC lead agencies to grow the Independent Living programs, establish connections with other agencies as needed, and develop training to improve skills and knowledge. The Department hosts monthly statewide independent living conference calls and provides face to face training bi-annually. In the fall of 2015 and spring of 2016, the Office of Child Welfare provided training for staff specialized in independent living services. The range of topics included: transition planning, Chafee related FSFN requirements, best practice for employment and housing, how to access additional funding, improving permanency outcomes for older youth and young adults, introduction to restorative justice for youth, and peer to peer sharing.

Although the Florida Reach network has been actively supporting the collaboration around the campus-based support initiative, the Department identified a need to expand and strengthen these efforts. In the upcoming year, the Department plans to secure a contract for services designed specifically to lead the

ongoing campus-based support initiative for youth formerly in foster care. With the execution of Positive Pathways for Transitioning Postsecondary Youth, services to organize the ongoing efforts will include:

- technical assistance,
- training and guidance to network members, community stakeholders, and former foster youth;
- organizing and delivery of a yearly conference for network members and stakeholders; and
- establishing dedicated campus coaches for students eligible for Florida's Tuition and Fee Exemption, as outlined in s. 1009.25, F.S., as part of ongoing collaboration with Department of Education, Board of Governors, and Florida College System.

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Chapter X. Fiscal and Statistical Information

CFS-101, Part I
U. S. Department of Health and Human Services
Administration for Children and Families

Attachment B
OMB Approval #0970-0426
Approved through September 30, 2017

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV

For Fiscal Year 2018: October 1, 2017 through September 30, 2018

1. State or Indian Tribal Organization (ITO): Florida	**2. EIN: 59-3458463**
3. Address: Florida Department of Children and Families **1317 Winewood Boulevard** **Tallahassee, FL 32399-0700**	**4. Submission Type:** ☑NEW ☐REVISION
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) funds	$15,275,736
a) Total administrative costs (not to exceed 10% of title IV-B Subpart 1 estimated allotment)	$142,511
6. Total estimated title IV-B Subpart 2, Promoting Safe and Stable Families (PSSF) funds This line contains a formula to display the sum of lines 6a - 6f.	$18,866,452
a) Total Family Preservation Services	$4,410,976
b) Total Family Support Services	$6,690,044
c) Total Time-Limited Family Reunification Services	$3,773,291
d) Total Adoption Promotion and Support Services	$3,992,141
e) Total Other Service Related Activities (e.g. planning)	$0
f) Total administrative costs (FOR STATES ONLY: not to exceed 10% of title IV-B subpart 2 estimated allotment)	$0
7. Total estimated Monthly Caseworker Visit (MCV) funds (FOR STATES ONLY)	$1,188,402
a) Total administrative costs (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)	$118,840
8. Re-allotment of title IV-B subparts 1 & 2 funds for States and Indian Tribal Organizations:	
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS $_____ PSSF $_____ MCV (States only) _____	
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS $_____ PSSF $_____ MCV (States only) $_____	
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (FOR STATES ONLY) Estimated amount plus additional allocation, as available.	$1,274,712
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds	$6,234,797
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment).	$1,870,439
11. Estimated Education and Training Voucher (ETV) funds	$2,023,207
12. Re-allotment of CFCIP and ETV Program funds:	
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out the CFCIP Program.	$0
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out the ETV Program.	$0
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for the CFCIP Program.	Equitable share
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for the ETV Program.	Equitable share

13. Certification by State Agency and/or Indian Tribal Organization:

The State agency or Indian Tribal Organization submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.

Signature of State/Tribal Agency Official	*Signature of Central Office Official*
Title **Director of Revenue Management**	*Title*
Date 5/15/2017	*Date*

CFS-101, Part II
U. S. Department of Health and Human Services
Administration for Children and Families

Attachment B
OMB Approval #0970-0426
Approved through September 30, 2017

CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services

State or Indian Tribal Organization (ITO): Florida

For FY 2018: OCTOBER 1, 2017 TO SEPTEMBER 30, 2018

SERVICES/ACTIVITIES	(A) IV-B Subpart I-CWS	(B) IV-B Subpart II-PSSF	(C) IV-B Subpart II-MCV *	(D) CAPTA*	(E) CFCIP	(F) ETV	(G) TITLE IV-E	(H) STATE, LOCAL & DONATED FUNDS	(I) Number Individuals To Be Served	(J) Number Families To Be Served	(K) Population To Be Served	(L) Geog. Area To Be Served
1.) PROTECTIVE SERVICES	$ 6,362,870			$ -			$ 53,815,068	$106,338,891	25608	NA	All Eligible Children	NA
2.) CRISIS INTERVENTION (FAMILY PRESERVATION)	$ -	$ 4,410,976		$ -			$ -	$ 8,843,328	11893	NA	All Eligible Children	NA
3.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	$ -	$ 6,690,044		$ 1,274,712			$ -	$ 19,067,998	82672	NA	Reports of Abuse/Neglect	NA
4.) TIME-LIMITED FAMILY REUNIFICATION SERVICES	$ 6,138,566	$ 3,773,291		$ -			$ 63,928,808	$ 88,828,476	8053	NA	All Eligible Children	NA
5.) ADOPTION PROMOTION AND SUPPORT SERVICES	$ 2,631,789	$ 3,992,141					$ 32,170,655	$ 48,227,864	3295	NA	All Eligible Children	NA
6.) OTHER SERVICE RELATED ACTIVITIES (e.g. planning)	$ -	$ -					$ -	$ -	NA	NA	NA	NA
7.) FOSTER CARE MAINTENANCE: (a) FOSTER FAMILY & RELATIVE FOSTER CARE	$ -						$ 15,460,391	$ 39,590,167	7094	NA	All Eligible Children	NA
(b) GROUP/INST CARE	$ -						$ 30,552,307	$ 40,761,118	2313	NA	All Eligible Children	NA
8.) ADOPTION SUBSIDY PYMTS.	$ -						$ 87,300,646	$ 86,045,044	36753	NA	All Eligible Children	NA
9.) GUARDIANSHIP ASSISTANCE PAYMENTS	$ -						$ -	$ -	NA	NA	NA	NA
10.) INDEPENDENT LIVING SERVICES	$ -	$ -			$ 6,234,797		$ -	$ 15,959,609	1308	NA	Eligible 16-20	NA
11.) EDUCATION AND TRAINING VOUCHERS	$ -				$ -	$ 2,023,207	$ -	$ 5,803,829	1056	NA	Eligible 16-22	NA
12.) ADMINISTRATIVE COSTS	$ 142,511	$ -	$ 118,840				$ 3,394,309	$ 15,054,619				
13.) FOSTER PARENT RECRUITMENT & TRAINING	$ -	$ -		$ -			$ 42,269	$ 53,313				
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING	$ -	$ -		$ -			$ 278,551	$ 393,890				
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING	$ -						$ -	$ -	NA	NA	NA	NA
16.) STAFF & EXTERNAL PARTNERS TRAINING	$ -	$ -		$ -	$ -	$ -	$ 14,130,464	$ 7,208,757				
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING	$ -	$ -	$ 1,069,562				$ 4,250,079	$ 2,396,808				
18.) TOTAL	$ 15,275,736	$ 18,866,452	$ 1,188,402	$ 1,274,712	$ 6,234,797	$ 2,023,207	$305,323,547	$484,573,711	180045	0	0	
19.) TOTALS FROM PART I	$15,275,736	$18,866,452	$1,188,402	$1,274,712	$6,234,797	$2,023,207						
20.) Difference (Part I - Part II)	$0	$0	$0	$0	$0	$0						

21.) Population data are included in the APSR/CFSP narrative, not above in columns I - L. ☐YES ☑NO

* These columns are for States only; Indian Tribes are not required to include information on these programs.
** Only states or tribes operating an approved title IV-E waiver demonstration may enter information for rows 1-6 in column (g), indicating planned use of title IV-E funds for these purposes.

2018 APSR

CFS-101, Part III
U. S. Department of Health and Human Services
Administration for Children and Families

Attachment B
OMB Approval #0970-0426
Approved through September 30,2017

CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Foster Care Independence (CFCIP) and Education And Training Voucher (ETV):
Reporting For Fiscal Year 2015 Grants: October 1, 2014 through September 30, 2016

1. State or Indian Tribal Organization (ITO): Florida	**2. EIN:** 59-3458463	**3. Address:** Florida Department of Children and Families 1317 Winewood Boulevard Tallahassee, FL 32399-0700				
4. Submission Type: ☑NEW ☐REVISION						
Description of Funds	***Estimated Expenditures for FY 15 Grants***	***Actual Expenditures for FY 15 Grants***	***Number Individuals served***	***Number Families served***	***Population served***	***Geographic area served***
5. Total title IV-B, subpart 1 funds	$ 14,837,131	$ 14,837,131		29690	all child welfare clients	N A
a) Administrative Costs (not to exceed 10% of title IV-B, subpart 1 total allotment)	$ 138,419	$ 219,809				
6. Total title IV-B, subpart 2 funds (This line contains a formula that will display the sum of lines a-f.)	$ 18,032,675	$ 18,032,675		29690	all child welfare clients	N A
a) Family Preservation Services	$ 4,983,753	$ 4,733,227				
b) Family Support Services	$ 4,526,171	$ 4,226,388				
c) Time-Limited Family Reunification Services	$ 3,993,931	$ 5,466,525				
d) Adoption Promotion and Support Services	$ 4,528,820	$ 3,606,535				
e) Other Service Related Activities (e.g. planning)	$ -	$ -				
f) Administrative Costs (FOR STATES: not to exceed 10% of total title IV-B, subpart 2 allotment)	$ -	$ -				
7. Total Monthly Caseworker Visit funds (STATES ONLY)	$ 1,134,760	$ 1,134,760				
a) Administrative Costs (not to exceed 10% of MCV allotment)	$ -	$ -				
8. Total Chafee Foster Care Independence Program (CFCIP) funds	$ 6,514,125	$ 5,906,927				
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	$ 1,954,238	$ 1,221,766		1294	30 year old youths	N A
9. Total Education and Training Voucher (ETV) funds	$ 2,096,227	$ 1,908,707		1072	22 year old	N A
10. Certification by State Agency or Indian Tribal Organization: The State agency or Indian Tribal Organization agrees that expenditures were made in accordance with the Child and Family Services Plan, which was jointly developed with, and approved by, the Children's Bureau.						
Signature of State/Tribal Agency Official	***Date*** 5/15/2017	***Signature of Central Office Official***			***Date***	
Title Staff Director of Revenue Management		***Title***				

ESTIMATED EXPENDITURES: State Fiscal Year 2014-2015
PROMOTING SAFE AND STABLE FAMILIES
Fiscal Data

Program/Service	Funding Source	Family Preservation Services		Family Support Services		Time-Limited Family Reunification Services		Adoption Promotion and Support Services	
		STATE	FEDERAL	STATE	FEDERAL	STATE	FEDERAL	STATE	FEDERAL
Associated Marine Institute-DJJ	DJJ -State and Federal Funds	9,159,467	40,963	0	0	0	0	0	0
Child Sexual Abuse Treatment Program - DCF	State Funds	3,234,825	0	0	0	0	0	0	0
Child Protection Teams - DOH	State Funds, SSBG	6,660,558	5,427,052	0	0	0	0	0	0
Child Care and Development Fund-OEL	SSBG/CDBG & TANF			172,773,415					
Children's Mental Health and Substance Abuse	DJJ -State and Federal Funds	49,437,644	6,583,867	0	0	0	0	0	0
	DCF – CMH and SA Block Grants, State Funds and SAMHSA project grant funds	122,814,709	42,071,535	0	0	0	0	0	0
CINS/FINS Runaway Shelter	DJJ -State Funds, Title IV-E	30,124,057	750,000	0	0	0	0	0	0
Comm-Based Family Resource	State, Family Resource & Support	0	0	143,463	573,852	0	0	0	0
Community Food & Nutrition	Comm Food & Nutrition Grant	0	0		258,831,350	0	0	0	0
Day Care Quality Improvement	CCDBG, SSBG and State	0	0	1,663,437	9,884,345	0	0	0	0
Day Care Resource & Referral	CCDBG, SSBG and State	0	0	698,651	4,266,778	0	0	0	0
Domestic Violence	Family Violence Prev STOP,TANF,Encourage Arrest and State Funds	0	0	18,330,646	18,280,758	0	0	0	0
Early Intervention Services	State, IDEA, Part C	451,630	0	32,293,478	21,387,506	0	0	0	0
Epilepsy	State Funds	0	0	4,094,242	0	0	0	0	0
Family Planning	Title X, Family Planning, State	4,245,455	8,429,774	0	0	0	0	0	0
Family Safety	State, IV-E, IV-B, TANF	97,039,950	80,925,754	27,491,036	8,495,063	2,351,253	7,265,941	35,196,541	40,900,249
Full Service Schools	DOH - State funds	0	0	6,000,000	0	0	0	0	0
Healthy Families	TANF, State	0	0	16,442,699	5,717,467	0	0	0	0
Improved Pregnancy Outcome	Maternal & Child Health Blk Grant	0	0	19,925,176	4,498,396	0	0	0	0
Interstate Compact/ ISS	State Funds, IV-E, TANF and SSBG	202,733	498,910	0	0	0	0	0	0
Local Services Program	Refugee Assistance Fed Grants	0	0	0	55,001,087	0	0	0	0
Ounce of Prevention	State	0	0	1,804,931	0	0	0	0	0
PACE	State Funds	0	0	13,643,405	0	0	0	0	0
Primary Care (CMS)	Maternal & Child Health Blk Grant	0	0	3,296,315	2,943,042	0	0	0	0
Protective Services Staff - DJJ	SSBG,Med Asst,TANF, CWS-State, & Title IV-E		43,265,437	0	0	0	0	0	0
Protective Services Staff - DCF		82,969,797	106,961,721	0	0	0	0	0	0
Regional Perinatal Program		0	0	230,009	0	0	0	0	0
School Health		0	0	10,909,412	11,625,846	0	0	0	0
Women, Infants & Children Program	Women, Infants & Children Program	0	0	0	322,080,776	0	0	0	0
Totals by Program AREA & FUND SOURCE		**406,340,825**	**294,955,013**	**329,740,315**	**723,586,268**	**2,351,253**	**7,265,941**	**35,196,541**	**40,900,249**

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1992 Comparision to 2015 for State and Local Funds
Expended for Non-supplantation Requirements related to Tiltle IV-B, Part II Services

Period	Family Preservation Services	Family Support Services	Time-Limited Reunification	Adoption Promotion	Total
2015	$ 406,340,825	$ 329,740,315	$ 2,351,253	$ 35,196,541	$ 773,628,934
1992	$ 85,737,000	$ 311,374,000	$ -	$ -	$ 397,111,000
Diff 2015 from 1992	$ 320,603,825	$ 18,366,315	$ 2,351,253	$ 35,196,541	$ 376,517,934

Funds have not been supplanted to meet this federal requirement to equal or exceed the amount spent in 1992 for Family Preservation and Family Support Services as stated in 45 CFR 1357.32(f).

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State Share (MOE)
to verify no Supplantation

State Fiscal Year	Family Preservation	Family Support	Time-Limited Reunification	Adoption Promotion	Total State Share
1992-93	85,737,000	311,374,000			397,111,000
1993-94	89,683,000	308,635,000			398,318,000
1995-96	102,734,000	306,787,000			409,521,000
1996-97	102,590,000	334,424,000			437,014,000
1997-98	124,226,000	402,301,000			526,527,000
1998-99	N/A	N/A			
1999-00	212,523,589	294,346,482			506,870,071
2000-01	289,717,496	360,844,036			650,561,532
2001-02	307,322,358	313,008,601			620,330,959
2002-03	319,416,329	236,847,274			556,263,603
2003-04	272,524,635	271,865,884			544,390,519
2004-05	328,146,128	283,185,887			611,332,015
2005-06	281,122,688	300,453,611			581,576,299
2006-07	257,220,980	345,495,146			602,716,126
2007-08	360,971,684	323,522,062			684,493,746
2008-09	329,768,367	311,966,459			641,734,826
2009-10	325,476,156	297,103,746			622,579,902
2010-11	342,517,176	295,846,645			638,363,821
2011-12	321,598,115	276,823,942			598,422,057
2012-13	290,890,344	279,328,784			570,219,128
2013-14	351,849,429	276,314,954	1,616,125	33,927,768	663,708,276
2014-15	406,340,825	329,740,315	2,351,253	35,196,541	773,628,934

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Title IV-B, subpart I FFY 2005
Historical Comparsion for Payment Limitations

Source: IDS Grants

cobj	OCA Title	oca	Total Expenditures	Total Federal	Total State
PCW05	FS-PROGRAM ADMINISTRATION	BT000	158,329.35	118,747.01	39,582.34
PCW05	FS/QUALITY ASSURANCE UNIT	FFQAU	867.60	650.70	216.90
PCW05	PDC TRNG PROTECTIVE SVCS	PDC02	(223.13)	(167.35)	(55.78)
PCW05	PDC TRNG FOSTER CARE	PDC03	(831.43)	(623.57)	(207.86)
PCW05	PDC TRNG ADOPTION PLACEMENT	PDC04	(163.11)	(122.33)	(40.78)
PCW05	SF CHILD WELFARE OH ADMIN-CBC	PR024	1,637,628.13	1,228,221.10	409,407.03
PCW05	IV-B CHILD WELFARE OH ADMIN-CBC	PR026	10,931,006.61	8,198,254.96	2,732,751.65
PCW05	**IV-B CHILD WELFARE OHC MAINT-CBC**	**PR046**	**513,148.45**	**384,861.34**	**128,287.11**
PCW05	IV-B IN HOME	PR126	3,728,406.04	2,796,304.53	932,101.51
PCW05	IV-B CHILD WELFARE IH-CBC	PRA26	1,325,379.83	994,034.87	331,344.96
PCW05	IV-B CHILD WELFARE ADOPT ADMIN-CBC	QACM0	90,294.12	67,720.59	22,573.53
PCW05	QUALITY ASSURANCE & CONTRACT MGT	RSFL0	599.05	449.29	149.76
PCW05	FRONT LINE RETENTION STRATEGY	RSL00	952.83	714.62	238.21
PCW05	RETENTION STRATEGY-LOAN REIMB	WG000	559,669.77	419,752.33	139,917.44
PCW05	PROTECTIVE SVCS FOR CHILDREN	WH000	1,328,079.23	996,059.42	332,019.81
PCW05	**FOSTER CARE PRG ADMIN**	**WO004**	**320,317.47**	**240,238.10**	**80,079.37**
PCW05	CHILD WELFARE MAINT PYMTS-OHS	WOA00	163,614.16	122,710.62	40,903.54
PCW05	CHILD WELFARE PROGRAM ADMIN	WY000	117,226.36	87,919.77	29,306.59
	TOTAL TITLE IV-B, PART I FFY 2005		**20,874,301.33**	**15,655,726.00**	**5,218,575.33**

			Total	IV-B Federal	IV-B State
PCW05	**IV-B CHILD WELFARE OHC MAINT-CBC**	**PR046**	**513,148.45**	**384,861.34**	**128,287.11**
PCW05	**CHILD WELFARE MAINT PYMTS-OHS**	**WO004**	**320,317.47**	**240,238.10**	**80,079.37**
	Title IV-B FC Maintenance Payments for FFY 2005		833,465.92	625,099.44	208,366.48

No Child Care or Adoption Assistance Payments were paid from FFY 2005 Title IV-B, subpart I grant funds or used as state match for the grant.

	Amount State Share
Non Federal funds expended by the state for Foster Care Maintenance Payments for FFY 2005	87,983,633.35

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Appendix A.

Florida's Continuous Quality Improvement (CQI) Plan

Florida's CQI System

Florida's Continuous Quality Improvement (CQI) System Plan is an intricate part of Florida's Child and Family Services Plan 2015-2019. The link for the CFSP and full CQI System Plan on Florida's Center for Child Welfare is

http://centerforchildwelfare.fmhi.usf.edu/ChildFamilyServicesPlan.shtml

During this reporting cycle, Florida's CQI system was fully implemented on July 1, 2015. The CFSR Onsite Review Instrument (OSRI) and Online Monitoring System (OMS) was utilized for Florida CQI reviews in addition to the joint federal-state CFSR round 3 review conducted between April 1, 2016 and September 30, 2016. Florida CQI case reviews completed in the OMS system during the report period totaled 457. Data from these reviews helped to guide the statewide assessment on many items. During this same period, CBC QA staff also completed Rapid Safety Feedback (RSF) reviews of 816 cases. This process focuses on child safety in in-home service cases involving children under four years of age who have multiple risk factors such as parental substance abuse; and domestic violence history.

The regional Critical Child Safety Practice Experts conducted 3,003 case reviews and consultations between October 2015 and September 2016. This process focuses on child safety during child protective investigations involving children under four years of age who have multiple risk factors such as parental substance abuse; and domestic violence history. The Critical Child Safety Reviewer engages the CPI and supervisor in discussions about patterns, potential danger threats, parental protective capacities, and child vulnerability.

Please refer to Appendix A, Florida's Five Year CQI Plan for 2015-2019.

SECTION 6: FLORIDA'S FIVE YEAR CQI PLAN FOR 2015-2019

FLORIDA'S CHILD WELFARE CQI SYSTEM FIVE YEARS FROM NOW

OUR VISION….

…. is to create a child welfare continuous quality improvement system that identifies, describes and analyzes child welfare system strengths and problems and implements improvements through a coordinated approach to use quantitative and qualitative data to inform goals and strategies for policy, field practice, training, and overall system improvement.

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GOAL 1: STRENGTHEN THE CQI FOUNDATIONAL STRUCTURE

STRENGTHS:

- Florida statutes designate DCF as the State agency with authority and oversight over the implementation of a CQI system
- Florida implements this authority with policy, Windows into Practice, the DCF Office of Child Welfare Annual Quality Management Plan, grant agreements with the Sheriff Departments, and CBC contracts
- Written job descriptions for CQI staff require specific education, knowledge, and skills necessary to accomplish CQI duties
- Florida requires all CQI staff to participate in specialized training and CQI staff must pass a competency assessment
- Florida's CQI polices, operating procedures, and practices are accessible to all CQI staff and individuals participating in CQI activities via the Center for Child Welfare at the University of South Florida. The Center acts as the learning center and repository for child welfare training, reports, polices, etc.
- Florida demonstrates the capacity and resources to support the operation of a comprehensive CQI process with dedicated staff at the state and regional level, as well as all CBC's and the Sheriff Departments.

GOAL 1: ENSURE CONFORMITY WITH TITLE I-B AND IV-E CHILD WELFARE REQUIREMENTS USING A FRAMEWORK FOCUSED ON SAFETY, PERMANENCY, AND WELL-BEING THROUGH SEVEN OUTCOMES AND SEVEN SYSTEMIC FACTORS

Current State	Future State	5-Year Action Plan
Initiative 1.1 Adopt New QA Review Items The state currently uses a set of review items that are not in complete conformity with the new Child and Family Service Review (CFSR) items. For in-depth reviews, the state uses the Quality Service Review Protocol. Supporting Information: • CFSR Technical Bulletin #7 (Cover Letter) March 2014 • CFSR Technical Bulletin #7 March 2014	The state uses the CFSR items for case reviews and the CFSR web based tool for in-depth reviews.	**Year 3** 1. Case review items are revised to comport with the CFSR Items. 2. QSR is eliminated and the CFSR case review is fully implemented. **Complete** Florida began using the CFSR Onsite Review Items October 1, 2014 and have entered findings in the Florida DCF QA Web Portal. Beginning April 1, 2015, all QA reviews of the services component are being done using the Online Review Instrument and Instructions. Florida no longer uses the QAR items and instrument. (Attachment 1)

Initiative 1.2 CFSR Review Process Administration for Children and Families conducts the case review process for CFSR. Supporting Information: • CFSR Technical Bulletin #7 (Cover Letter) March 2014 • CFSR Technical Bulletin #7 March 2014	The state will conduct the case review process of the CFSR. This supports the state's capacity to self-monitor for child and family outcomes, systems functioning and improvement practices.	**Year 3** 1. Letter of Intent submitted to the Children's Bureau. **Complete** Letter of Intent submitted to the Children's Bureau on 9/8/2014. 2. Statewide Assessment and Integration with the CFSP to evaluate performance on CFSR outcomes and systemic factors. **Complete** Statewide Assessment finalized March 2016. 3. Develop sampling methodology and sample sizes for review and approval by the Children's Bureau. **Complete** Florida worked with the Children's Bureau and MASC via several conference calls to establish and finalize the CFSR sample frame. The CFSR sample frame was approved by the MASC. 4. Provide CFSR training for all CBC and region QA reviewers using the Children's Bureau training. **Complete** CBCs continued to utilize the CFSR training modules for staff

		training. All CQI staff are required to complete the online training. 5. Develop 3rd party review process and identify 3rd party reviewers. **Complete** Process finalized and implemented for Round 3 CFSR. The state office is responsible for second level QA reviews. The state has identified three positions in the state child welfare office to conduct the second level review of all CFSR cases. 6. Train 3rd party reviewers to ensure consistency of reviews. **Complete** The CFSR process includes a QA completed by the Community-based Care lead agency QA manager; a second level review completed by the state office, and a final review by the Children's Bureau. 7. Develop Conflict of Interest statement for all reviewers to sign. **Complete** Form has been finalized and is in use. 8. Participate on joint federal-state team to interview stakeholders and

		assess the state's functioning on the seven system factors. **Complete** The Children's Bureau conducted stakeholder interviews during the summer of 2016. The state office participate on the joint team as requested. 9. Send case review schedules to the Children's Bureau for the period of April 1-September 30, 2016. **Complete** The 2016 CFSR schedules established and provided to the Children' Bureau. 10. Conduct case reviews during the period of April 1-September 30, 2016. **Complete** CFSRs began April 1, 2016 and ended September 30, 2016. 11. Submit results to the Children's Bureau by November 15, 2016. **Complete** Final Round 3 CFSR report received in December 2016.
Initiative 1.3: Program Improvement Plan After a CFSR is completed, states develop a Program Improvement Plan (PIP) to address areas in their child	No change	**Year 3** 1. Develop a PIP following instructions issued by the Children's Bureau on all "areas needing improvement".

welfare services that need improvement. Source Documents: Federal 45 CFR 1355.35		**Complete** PIP submitted 3/28/17. PIP approved 5/22/17. Incorporate elements of the PIP into the goals and objectives of the CFSP and address its progress in implementing the PIP in the Annual Progress and Services Report (APSR) (45 CFR 1355.35(f)). **Complete** Year 3 APSR modified to incorporate elements of PIP.

GOAL 2: STRENGTHEN THE CQI FOUNDATIONAL STRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
Initiative 2.1: Update Sheriff Grant Agreements The sheriffs in six counties (Pasco, Pinellas, Manatee, Broward, Hillsborough, and Seminole counties) are authorized by s. 39.3065(3)(d), F.S., to develop their own quality assurance review system to assess the quality of work performed by child protective investigators. Florida Statutes requires that program performance evaluation be based on criteria mutually agreed upon by the respective sheriffs and the Department. Sheriffs are required by Grant Agreement to conduct annual program evaluation.	A statewide standardized system for child welfare CQI activities that includes the entire child welfare continuum from intake through Sheriffs and state operated child protective investigations and case management services.	**Year 1** 1. With input from Sheriffs and regional child protection staff align Sheriff QA case reviews with state child protection QA case reviews. **Complete**

GOAL 2: STRENGTHEN THE CQI FOUNDATIONAL STRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
		Year 3 2. Provide access to the Department's QA web portal to the Sheriffs. **Complete** The Sheriffs will begin completing QA reviews in Qualtrics using the Department's portal in the summer of 2017.

GOAL 2: STRENGTHEN THE CQI FOUNDATIONAL STRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
Initiative 2.2: Formalize Position Descriptions for QA reviewers The state does not require formalized position descriptions for QA reviewers that outline the minimum education and experience needed for the position, and duties and responsibilities.	Statewide standardization of position descriptions so that staff performing case reviews have uniformity in duties and responsibilities and management has a clear path for recruiting employees with the necessary education, knowledge, skills, and abilities.	**Year 3** 1. Establish a workgroup to review position descriptions of QA staff and make recommendation of core requirements. **Complete** 2. Solicit feedback on core requirements from all affected parties (regions, Sheriffs, and CBCs). **Update** Core requirements and position descriptions for QA Critical Child Safety Teams complete. 3. Finalize requirements in Sheriff Grant agreements and CBC contracts. **Update** The sheriffs have incorporated most of the Rapid Safety Feedback items into their QA review tool. The Department assisted the Sheriffs and incorporated the QA review tool into the Department's Qualtrics. The Sheriffs QA reviews will use revised tool in the summer of 2017.

GOAL 3: COLLECT QUALITY DATA BOTH QUANTITATIVE AND QUALITATIVE FROM A VARIETY OF SOURCES		
STRENGTHS: **Florida captures and analyzes quantitative and qualitative data from case reviews and the SACWIS system.**		
Current State	**Future State**	**5-Year Action Plan**
Initiative 3.1: Statewide Reporting of Trends and Practices Statewide reporting of trends and practices of qualitative and quantitative information does not occur. Supporting information: • March 6, Questions for Further Exploration from the Children's Bureau noting this is an area for further improvement. • April 4, 2013 letter from the Children's Bureau noting this as an area needing improvement.	The state produces an annual comprehensive child welfare evaluation report that incorporates data from a variety of sources (CPI and Sheriff reviews; child fatalities; independent living; extended foster care) and a full assessment of systemic factors (case review system; QA system; staff and provider training; service array and resource development; agency responsiveness to the community; and foster and adoptive parent licensing; recruitment; and retention).	**Year 3** 1. Identify funds and designated personnel to participate in research, analysis and report writing. a) Produce annual reports for practice areas including child fatalities, independent living, extended foster care, CLS reviews, and Sheriffs. 2. Develop a project implementation plan that establishes short and long term goals and strategies. Map out a process for an annual assessment of the following: a) case review system; b) QA system; c) staff and provider training; d) service array and resource development;

		e) agency responsiveness to the community; and f) foster/adoptive parent licensing; recruitment and retention **Update** The Public Facing Results Oriented Accountability Interactive Child Welfare Dashboards are available on the DCF Internet: http://www.dcf.state.fl.us/programs/childwelfare/dashboard/ The Child Welfare Dashboards include a home page that offers child welfare statistics at a glance where users can then interface deeper into current and historical data on topics that include allegations accepted by the Florida Abuse Hotline for child protective investigation, children that are included in protective investigations, children who receive services, child removal rates, and children entering and leaving out-of-home care. The home page will be updated by the 15th of each month and show the latest 24 months of child welfare information. Through ROA, the Department aims to improve access to good quality data, build analytical capacity of staff to use data, take action to improve outcomes, and continue to develop a results-oriented culture of shared accountability, transparency and collaboration with a focus on research and evidence-based interventions. These child welfare dashboards marks the first of a series of releases. Future releases will include child protective investigation views, safety methodology views, CBC Views, Child Welfare Practice drivers, Child Welfare Outcomes, and Florida Continuous Quality views.

GOAL 3: COLLECT QUALITY DATA BOTH QUANTITATIVE AND QUALITATIVE FROM A VARIETY OF SOURCES.		
Current State	**Future State**	**5-Year Action Plan**
Initiative 3.2: Collection of Data on Service Array The state does not have a process for identifying and assessing service gaps and how services are individualized. Supporting information: • March 6, Questions for Further Exploration from the Children's Bureau noting this is an area for further improvement.	A service gap analysis annually to identify service needs.	**Year 3** 1. Identify funds for annual service gap analysis. 2. Complete RFI for state term contract. 3. Implement a process for how CBCs will use the information to make local system changes. **Update** The Department completed the assessment of safety management and family support services and established a baseline. During this next phase the Department is focusing on treatment and child well-being services.
Initiative 3.3: Data Integrity The state does not have a process for formal data integrity including a written manual or protocol that establishes a process for monitoring data quality and reliability. There is not a process address data quality and reliability issues.	Data integrity is an accepted practice by line staff and processes are in place to continually monitor and address data integrity issues.	**Year 3** 1. Develop a series of reports for critical data integrity issues and a corrective action plan to ensure action is taken to correct deficiencies. **Completed in Year 1**

GOAL 3: COLLECT QUALITY DATA BOTH QUANTITATIVE AND QUALITATIVE FROM A VARIETY OF SOURCES.		
Current State	**Future State**	**5-Year Action Plan**
Supporting information: • March 6, Questions for Further Exploration from the Children's Bureau noting this is an area for further improvement		The Department has created a child welfare dashboard with corresponding child listing reports. Regions and CBC can review listing reports to identify areas that need to be addressed. Additionally, the Office of Performance Management is producing a Child Welfare Monthly Key Indicator Report that is provided to regional leadership and CBCs so that trend are monitored and action is taken as needed.

GOAL 4: STRENGTHEN THE QA CASE REVIEW AND PROCESS		
STRENGTHS: • Florida's case review system assesses practice by regularly scheduled case specific reviews in all geographic areas. • The case review instruments collect data, assess agency performance, and reflect systemic factors in key child welfare areas. • Florida's Windows into Practice provides written guidance regarding case elimination. • Florida's CQI staff are trained and certified to perform case record reviews.		
Current State	**Future State**	**5-Year Action Plan**
Initiative 4.1: Stakeholder Participation The CQI system does not require stakeholders to participate on QA reviews. Although foster parents have participated on two statewide QA reviews, they do not participate at the local level. Qualitative reviews do not include any of the community stakeholders who could bring a different perspective to system issues. Supporting information: • March 6, Questions for Further Exploration from the Children's Bureau noting this is an area for further improvement. • April 4, 2013 letter from the Children's Bureau noting this as an area needing improvement.	Community stakeholders routinely participate in qualitative case reviews and stakeholder interviews to assess local community systems. Stakeholders include, but are not limited to, policy and training specialists; operations and management administrators; foster parents; Foster Parent Association; law enforcement; Tribes; Child Protection Teams; CLS; GALs; school systems; university Schools of Social Work; community alliances; mental health professionals; substance abuse professionals; and legislative staff.	**Year 3** 1. Create local stakeholder groups with people that are interested in participating in QA reviews. 2. Develop roles and responsibilities of stakeholders when participating on a QA review. 3. Develop a short training program for stakeholder participants. **Update** The CQI system includes protocol for local stakeholders who participate on a QA review. Included are confidentiality agreements, conflict of interest, and training. **Year 3** 4. Implement stakeholder participation statewide. **Update**

		CBCs are encouraged to continue to reach out to stakeholders for participation in Florida CQI reviews.

GOAL 4: STRENGTHEN THE QA CASE REVIEW AND PROCESS		
Current State	**Future State**	**5-Year Action Plan**
Initiative 4.2: Second Level QA Reviews Florida permits case reviews to be conducted by the CBC lead agencies with responsibility for oversight of the service provision. The state does not have a process for 2nd level reviews. Supporting information: • March 6, 2013 Questions for Further Exploration from the Children's Bureau noting this is an area for further improvement. • April 4, 2013 letter from the Children's Bureau noting this as an area needing improvement.	The state has a 2nd level review process that ensures data integrity of information obtained through case reviews.	**Year 3** 1. Collaborate with the state QA team representing the regions, CBCs, and Sheriffs to develop a second level review process. 2. Incorporate the second level review process into the "Windows into Practice" guidelines. **Complete** Process for second level QA is in place and implemented during the round 3 CFSR. The state office has three staff to conduct second level QA reviews.
Initiative 4.3: Conflict of Interest Statements The state does not require conflict of interest statements for reviewers. Supporting information:	All staff that conduct case reviews complete a conflict of interest statement that ensures the reviewer does not have a conflict or perceived conflict	**Year 3** 1. Establish a workgroup to develop a proposed conflict of interest statement. 2. Solicit review and approval of the statement by the statewide QA

GOAL 4: STRENGTHEN THE QA CASE REVIEW AND PROCESS		
Current State	**Future State**	**5-Year Action Plan**
• March 6, 2013 Questions for Further Exploration from the Children's Bureau noting this is an area for further improvement. • April 4, 2013 letter from the Children's Bureau noting this as an area needing improvement.	with the organization under review.	managers representing the Sheriffs, regions, and CBCs. 3. Formal review by the Office of General Counsel. 4. Include in the Windows into Practice" guidelines. **Complete.** The Windows into Practice includes a conflict of interest process. CBCs are required to have all team members sign statements. **Year 3** 5. Incorporate into QA certification training. **Complete.** Florida training incorporated the requirement for Conflict of Interest Statements.
Initiative 4.4: Case Elimination Protocol Florida does not have an established case elimination protocol for CPI and Sheriff case reviews. Supporting information: • March 6, 2013 Questions for Further Exploration from the	There is a standardized case elimination protocol for child protective investigations and case management.	**Year 3** 1. Establish a workgroup that includes regions, CBCs, and Sheriffs to develop a proposed case elimination protocol. 2. Solicit review and approval of the protocol by the statewide QA managers representing the Sheriffs, regions, and CBCs.

GOAL 4: STRENGTHEN THE QA CASE REVIEW AND PROCESS		
Current State	**Future State**	**5-Year Action Plan**
Children's Bureau noting this is an area for further improvement. • April 4, 2013 letter from the Children's Bureau noting this as an area needing improvement.		3. Include in the Windows into Practice" guidelines. **Complete.** The state implemented the case elimination process and incorporated the requirements into the Windows into Practice. It was used in the 2016 CFSRs.

GOAL 5: ENHANCE FEEDBACK AND ADJUSTMENT ACTIVITIES		
STRENGTHS: • Florida organizes and displays quantitative and qualitative data via the DCF websites and the Center for Child Welfare at the University of South Florida. • Florida presents data to internal and external stakeholders.		
Current State	**Future State**	**5-Year Action Plan**
Initiative 5.1: Use of data to inform planning, monitoring and adjustment at all levels of the Department The state does not have a coordinated strategy to use quantitative and qualitative data to inform goals and strategies for policy, field practice, training, and overall improvement of the child welfare system. Supporting information: • March 6, 2013 Questions for Further Exploration from the Children's Bureau noting this is an area for further improvement. • April 4, 2013 letter from the Children's Bureau noting this as an area needing improvement.	The state has a child welfare continuous quality improvement system that identifies, describes and analyzes child welfare system strengths and problems and implements improvements through a coordinated approach to use quantitative and qualitative data to inform goals and strategies for policy, field practice, training, and overall system improvement.	**Year 3** 1. Establish an inter-departmental workgroup tasked with establishing a formal process for annual planning 2. Planning includes a review of data from systemic factors; quantitative and qualitative data; and child welfare reports. 3. Share information with stakeholders and solicit feedback. 4. Revise the child welfare strategic plan to address activities needed. **Complete.** The state publishes a Monthly Key Indicators Report that is available on-line to DCF regions, CBCs and the public. The Key Indicators Report includes qualitative case review findings.

GOAL 5: ENHANCE FEEDBACK AND ADJUSTMENT ACTIVITIES		
Current State	**Future State**	**5-Year Action Plan**
Initiative 5.2 Stakeholder Feedback The state does not have a formal process to gather and use feedback from all stakeholders in Florida's planning and adjustment of the child welfare system. Supporting information: • March 6, 2013 Questions for Further Exploration from the Children's Bureau noting this is an area for further improvement. • April 4, 2013 letter from the Children's Bureau noting this as an area needing improvement.	The state obtains feedback from stakeholders annually and uses the information in planning and adjustment of the child welfare system.	**Year 3** 12. Identify funds for the facilitation of six regional stakeholder groups and development of a formal report that can be used for statewide planning. 13. Complete RFI for state term contract. 14. Identify child welfare practice experts to participate in the stakeholder meetings. 15. Incorporate CFSR stakeholder interview findings into the final report. **Ongoing.** The CFSR stakeholder interviews were conducted in June 2016. Information from these interviews was included in the final CFSR report issued in December 2016. The Child Welfare Task Force has the responsibility to lead, guide, direct, and advise the statewide implementation of major initiatives of which the PIP is one. The Task Force is comprised on stakeholders from multiple disciplines – judges, GAL, court personnel, CBCs, Region DCF

GOAL 5: ENHANCE FEEDBACK AND ADJUSTMENT ACTIVITIES		
Current State	**Future State**	**5-Year Action Plan**
		representatives, community partners, foster and adoptive parents, and others
Initiative 5.3: Research and Policy Development There is no formal, ongoing review of current literature or formal affiliations with child welfare research groups to stay abreast of the latest evidence-based practice recommendations. Likewise, there is no systematic examination or validation of internal practices in comparison to current literature. Supporting information: • April 4, 2013 letter from the Children's Bureau noting this as an area needing improvement.	Research findings are used to inform policy and practice; design training informed by research; promote supportive and strategic legislative agendas and requests; and prepare position papers to drive media responses and public relations efforts.	**Year 3** 1. Create a research workgroup. 2. Create a research agenda based on continuous quality improvement findings and input from stakeholders and program professionals. Ensure that the agenda links to the CFSP goals and the practice model. 3. Draft research briefing papers and circulate for workgroup review and internal review. 4. Publish research briefings. 5. Monitor action taken in response to the recommendations. **Complete.** The 2014 legislature established the Florida Institute for Child Welfare at the Florida State University School of Social Work under Section 1004.615, Florida Statutes. The Institute sponsors and supports interdisciplinary research projects and program evaluation initiatives that will contribute to a dynamic knowledge base relevant for enhancing Florida's child welfare

GOAL 5: ENHANCE FEEDBACK AND ADJUSTMENT ACTIVITIES		
Current State	**Future State**	**5-Year Action Plan**
		outcomes. The Institute provides nationally acclaimed child welfare research, training services, and policy and practice implementation guidance in support of the children and families in Florida's child welfare system. Institute Insights, a quarterly publication, was launched on May 1.
Initiative 5.4: University Partnerships The state maintains a partnership with the University of South Florida but has not fostered research projects through the Schools of Social Work at state universities. Supporting information: • Inability to produce in depth program evaluation.	The state has established relationships with schools of social work within the state university system. Program evaluation and research are an integral part of on-going program evaluation to improve child welfare practice.	**Year 1-5** Collaborate with the state university system to develop a partnership for program evaluation and research. **Update** The Department is continuing to work with the Florida Institute for Child Welfare at Florida State University. The Institute is a key partner in the Results Oriented Accountability Program and will lead initiatives related to researching model programs. This will support Florida's efforts to establish evidence based programs. See 5.3 above.

Appendix A.

Florida's Continuous Quality Improvement (CQI) Plan

Florida's CQI System

Florida's Continuous Quality Improvement (CQI) System Plan is an intricate part of Florida's Child and Family Services Plan 2015-2019. The link for the CFSP and full CQI System Plan on Florida's Center for Child Welfare is

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During this reporting cycle, Florida's CQI system was fully implemented on July 1, 2015. The CFSR Onsite Review Instrument (OSRI) and Online Monitoring System (OMS) was utilized for Florida CQI reviews in addition to the joint federal-state CFSR round 3 review conducted between April 1, 2016 and September 30, 2016. Florida CQI case reviews completed in the OMS system during the report period totaled 457. Data from these reviews helped to guide the statewide assessment on many items. During this same period, CBC QA staff also completed Rapid Safety Feedback (RSF) reviews of 816 cases. This process focuses on child safety in in-home service cases involving children under four years of age who have multiple risk factors such as parental substance abuse; and domestic violence history.

The regional Critical Child Safety Practice Experts conducted 3,003 case reviews and consultations between October 2015 and September 2016. This process focuses on child safety during child protective investigations involving children under four years of age who have multiple risk factors such as parental substance abuse; and domestic violence history. The Critical Child Safety Reviewer engages the CPI and supervisor in discussions about patterns, potential danger threats, parental protective capacities, and child vulnerability.

Please refer to Appendix A, Florida's Five Year CQI Plan for 2015-2019.

Appendix B

Florida's Foster and Adoptive Parent Diligent Recruitment Plan

Foster and Adoptive Parent Diligent Recruitment Plan

Florida's Foster and Adoptive Parent Diligent Recruitment Plan is a targeted plan within Florida's Child and Family Services Plan 2015-2019. The link for the CFSP and full Foster and Adoptive Parent Diligent Recruitment Plan on Florida's Center for Child Welfare is

http://centerforchildwelfare.fmhi.usf.edu/Publications/ChildFamilyServicesPlan.shtml

The plan has been updated to reflect the activities conducted during the reporting period to ensure that there are foster and adoptive homes that meet the needs of the infants, children, youth, and young adults (including those over the age of 18 who are in foster care) served by the child welfare agency.

Characteristics of children for whom foster and adoptive homes are needed

The Department gathered data about the types of adoptive parent populations who successfully adopted during the last five years and gathered three months of data that describes the available children who do not have identified families and therefore require adoption recruitment efforts.

More than 3,000 children were adopted from foster care during each of the last six years, with approximately 47% being adopted by relative caregivers, 30.29% by foster parents and 23% by recruited families. Currently, and at any given point in time during the last several years, the number of children available for adoption who require recruitment efforts is 750. Florida Safe Families Network data from September 2016 document that the following demographics describe the available children who require recruitment efforts:

- Race: 49% are African American, 46% are Caucasian and 5% are a mix of other races
- Gender: 59% are male and 41% are female
- Age: 14% are 0-8 years of age; 27% are 9-13 years of age and 64% are 13-17 years of age.
- Sibling groups being adopted together: 45-50 sibling groups are available at any given point with 90% of them being sibling groups of two
- Length of Time since TPR:
  - 67% % have been in care less than 12 months since TPR
  - 21% have been in care between 12-24 months since TPR;
  - 6% have been in care between 24-36 months since TPR;
  - 2% have been in care 36-48 months since TPR and
  - 4% have been in care more than 48 months.

In order to meet the specific needs of children placed in communities across Florida, each of the Community-Based Care lead agencies delivering foster care and adoption services provided updated

descriptions of the characteristics of the children needing families on an annual basis. The goal is to ensure agencies are tailoring their recruitment efforts to meet needs.

Major Recruitment Initiatives and Activities

The Intelligent Recruitment Project (IRP), continues to be administered by the Department in partnership with Community Based Care lead agencies, and is expected to demonstrate the impact of using marketing strategies to identify resource families for youth with challenging needs and who may remain in foster care for more than two years. The project uses an intelligence-driven approach to diligent recruitment based on "Intelligent Imagination™" -- a value and behavior based multi-layered strategic marketing process used by many Fortune 500 companies. Attachment A (to this Appendix), Florida Intelligent Recruitment Project Information, provides additional information on the IRP.

IRP's overarching goal is to establish and implement a strategic recruiting process that will permit every child to have a permanent home, with a secondary goal to develop a model site that can provide significant evidence-based programmatic guidance to:

- Develop and Implement a strategic marketing-based model for Diligent Recruitment
- Improve Permanency Planning Options and Outcomes with Diligent Recruitment Programs
- Strengthen training for newly recruited perspective resource families
- Enhance the pool of perspective resource families to more accurately reflect the out-of-home care population needs.

Project objectives are established with the intent of contributing to a national body of knowledge pertaining to the impact and effectiveness of strategic and targeted marketing efforts within the context of a Diligent Recruitment program. The outcomes of these targeted marketing efforts will be used to revise CBC, regional, and statewide targeted recruitment plans and expected outcomes.

The Department and partners have completed year three of this five-year grant. The participating CBCs include:

- Kids Central, Incorporated
- Heartland for Children
- Our Kids, Incorporated
- Big Bend Community-Based Care

The recruitment efforts in Florida have three main levels of focus. The individual Community-Based Care lead agencies develop CBC recruitment plans, which drive regional plans, which drive an overall statewide plan. These plans are intended to fulfill specific foster and adoptive home recruitment goals, which are developed in a process further detailed below in the section titled "Foster and Adoptive Home Recruitment Plans." In general, the planning process includes the following activities.

- Specific needs in CBC and regional plans shared and communicated via ongoing workgroups, which identifies challenges and barriers to recruiting and licensing foster homes.

- The Department then takes identified challenges and barriers and develops proposed solutions, which are submitted back to the workgroups for review and input.
- Statewide solutions, such as streamlining the relicensing process and implementing quality standards for licensed foster parents, are then implemented. Continued improvements to the Unified Home Study process, and combined all purposes of home studies into one electronic format that changes parameters depending on the type of home study selected.
- The Department and CBCs also identify needs for recruiting for certain populations.
    - Homes for Teens – recruitment materials and media plan for recruiting foster and adoptive homes for teens.

In 2016 the Department continued Fostering Success, a Priority of Effort to increase Quality Foster homes. The Fostering Success goal is to increase quality foster homes for teens, siblings groups and children with special needs.

Foster and Adoptive Home Recruitment Plans

CBC recruitment plans drive regional plans, which drive the statewide plan. Specific foster and adoptive home goals are developed through a process that begins in April-May of each year. For adoptive home recruitment, the Office of Child Welfare Data Reporting Unit continues to develop preliminary recommendations for goals based on prior year out-of-home care information (see Adoption Targets FY-2015-16 on page 227). Adoption goals are then negotiated by the regions with the local CBCs, taking into consideration such details as judicial characteristics and increases in out-of-home care. The final agreed adoption goals are amended into each CBC's contract.

Foster home recruitment goals are derived locally using the out-of-home care trends from the prior year. In addition, the Department, CBCs, and Children's Medical Services partner to recruit Medical Foster Homes for children with special medical needs. The Medical Foster Care (MFC) program coordinator is responsible for recruitment activities. These activities are coordinated with the CBC licensing staff. Recruitment is not limited to existing licensed foster homes, but includes activities directed at publicizing the need for MFC parents in the community. Recruitment activities include but are not limited to:

- Attending a Department-approved parent preparation training course "guest night" and sharing about MFC;
- Distributing brochures in the community in various locations, particularly medical facilities;
- Displaying MFC posters in public places;
- Distributing information for public service announcements such as radio, television and newspapers;
- Purchasing billboard announcements;
- Submitting special interest newspaper articles and help wanted ads, and
- Community networking and announcements at community meetings.

The Regional Licensing offices establish what annual targets foster home goals will be, and monitor monthly as part of the statewide tracking of foster home licensing. See Counts of Licensed Foster Care Providers and Newly Licensed Providers on page 228.

Outreach and Dissemination Strategies

The Department continues to use strategies including internet and social media, and traditional strategies, such as collaborative workgroups, initiatives, and associations, in a broad approach to recruiting and informing potential and active foster/adoptive parents.

Internet and Social Media

The Department hosts or sponsors multiple websites to assist with recruitment including: myflfamilies.com/fosteringsuccess, adoptflorida.org, qpiflorida.com, jitfl.com, and centerforchildwelfare.fmhi.usf.edu/.

The first two websites, myflfamilies.com/fosteringsuccess, and adoptflorida.org, connect individuals interested in fostering or adopting through the Department to the appropriate local agency that can assist them in beginning the fostering or adoption process. Both sites include anecdotal information from experienced foster or adoptive parents, and give answers to frequently asked questions as well as dispel common myths that often are barriers to people thinking about fostering or adopting.

The other two websites, qpiflorida.com and jitfl.com, are training resources specifically designed to meet the in-service training requirements and general training needs of foster parents. Both websites routinely post webinars that have been created for and conducted by actual foster parents in response to needs expressed by the foster and adoptive community in Florida. These sites also both focus on enhancing quality of care for the children, and quality of experience for the parents.

In addition, Community-Based Care (CBC) agencies, case management organizations, and child placing agencies also have websites. Social media links are found on the websites, or are available through the major online services (such as Facebook and YouTube). The Department hosts a blog on its Facebook page featuring foster and adoptive parent experiences.

Fostering Success

In April 2015, the Department implemented a Priority of Effort, Fostering Success, to recruit quality foster homes with a goal of reducing the number of children residing in group homes. The activities of the Priority of Effort include assessing data regarding the numbers of children in group care verses out of home care and the number of new foster homes compared to home closures each month. Four (4) workgroups were formed: Foster Family Selection; Placement Matching; Marketing and Communications and Supports and Resources. The Department partnered with the Quality Parenting Initiative in this endeavor to lead the workgroups and promote information sharing through webcasts. The workgroups developed the following items to guide best practice:

- Recruitment And Retention Toolkit
- Resource Guide

- Marketing materials developed for foster parents and made available on the Department's website
- Improved statewide collaboration for ongoing development of recruitment and retention strategies

Quality Parenting Initiative

The Quality Parenting Initiative (QPI) continues to provide training and strategies to improve child safety, permanency, and well-being for children placed in Florida's out-of-home care system. It is designed to ensure that placement of children in an out-of-home care setting is with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion and ethnicity, special physical or psychological needs, any circumstances unique to the child, and family relationships.

The CBC lead agencies and other agencies provide prospective caregivers with all available information necessary to assist the caregiver in determining whether he or she is able to care appropriately for a particular child. Such careful attention to placement-matching details improves the ability of caregivers to provide the right support and parenting to children placed with them. Mentoring and coaching from foster parents to birth parents is encouraged as a "best practice" through QPI trainings. In addition, QPI is promotes the participation and engagement of foster care parents in the planning, case management, and delivery of services for children in Florida's out-of-home care system, which increases positive outcomes for children and families. See also the discussion of QPI as an ongoing strategy in Chapter IV, Goals and Objectives.

Adoptive Parent Training, Communication, and Organizations

The Department of Children and Families hosts a statewide training opportunity for adoptive parents twice a year, once in January and once in May. Nationally recognized adoption experts such as Loryn Smith, Pat O'Brien, and Dr. Wayne Dean conduct the training sessions. Each training contains a general information and question and answer session, conducted by the state's Adoption Policy Specialist.

The Department continues to collaborate with the Florida Association of Heart Galleries to provide general awareness as to the needs of the foster parents, respite, mentors, volunteers and adoptive families.

The Department's Communication Office works closely with foster/adoptive families and child welfare staff throughout the state to support recruitment efforts and to conduct public awareness events. This includes prevention events, legislative session activities, and partnerships with community-based care organizations.

The Florida State Foster Adoptive Parent Association (www.floridafapa.org) is a key partner in recruitment activities. The Association conducts quarterly training sessions, hosts an annual training conference, and attends Children's Week activities during Florida's annual legislative session. Partnership with the association provides opportunities for feedback from current caregivers for recruitment and retention efforts. The association provides wonderful examples of "real life" examples of foster care/adoption experiences to share with the media and others for recruitment purposes.

The Department continues to collaborate with One to One Child of Florida in the efforts to provide general information and recruitment efforts to Florida Foster and Adoptive community within Florida's Child Welfare community.

Information and Access Strategies

The Department uses and plans to continue use of several different strategies for access to information and services. Some of the strategies are local, based on the needs of the community, while others are statewide strategies.

Local:

- Weekend and after hours training classes.
- Community-based organizations delivering services in multiple locations (churches, neighborhoods, etc.), which helps with transportation issues.
- Providing child care services so that families can attend pre-service and in-service trainings. Individualized study processes when needed.
- Outreach by FSFAPA to local associations and individual parents.
- Designated staff at CBC lead agencies for foster parent liaison work.
- Foster parent mentors (voice of experience).
- Some CBCs conduct site visits when prospective parents inquire. The purpose of the site visit is to answer questions the parents have, and also to do a preview of the home to determine if there are any apparent barriers to becoming a foster or adoptive parent.

Statewide:

- In-Service Training available on-line.
- Streamlined home study and relicensing processes.
- Quarterly mini-conferences and annual Educational Conference sponsored by the Florida State Foster/Adoptive Parent Association (FSFAPA) and supported by the Department and the Florida Coalition for Children.
- Multiple websites for obtaining information, such as Explore Adoption, adoptflorida.org., and its associated Adoption Information Center, 1-800-96ADOPT.

Explore Adoption is a statewide adoption initiative aimed at promoting the benefits of public adoption. Explore Adoption urges families to consider creating or expanding their families by adopting a child who is older, has special needs, or is a part of a sibling group. Through public education, expanded partnerships and social media, Explore Adoption invites Floridians to learn more about the children immediately available for adoption in their home state and community. The initiative puts a new face on public adoption by telling many stories of families who have enriched their lives by adopting Florida's children. Since the beginning of Governor Scott's administration, Florida has reduced the number of children available for adoption without an identified family from 850 to 750 on any given day. This can be tied to several initiatives:

- diligent training efforts from the state Office of Child Welfare with adoption specialists across the state;
- identification of a system setting in Florida's SACWIS system that was preventing posting of some siblings; and
- increased coordination with Heart Galleries to post children simultaneously on both the Heart Gallery and Department websites.

Training for Diverse Community Connection

The Department is committed to diversity in community connections and will continue to employ strategies such as:

- Online training resources available at the Department's child welfare portal, Center for Child Welfare: http://centerforchildwelfare.fmhi.usf.edu/Publications/CulturalCompetencyDiversityPub.shtml
- DCF will continue to host the Child Protection Summit annually – this comprehensive conference has plans to include annual opportunities for diversity training, such as working with children who have special needs, and being sensitive to children's cultures.
- DCF will collaborate with strong community advocates to foster understanding of and provide guidance related to matters impacting lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth in care.
- The Florida Coalition for Children also hosts an annual training conference – another potential resource for diversity training.
- The Adoption Information Center and the Department host statewide in-service adoption trainings, one in January and one in May. Nationally recognized adoption experts such as Loryn Smith, Pat O'Brien and Dr. Wayne Dean conduct the two-day training. The attendees include adoption case managers, adoption supervisors, Guardians ad Litem, private adoption agency staff, and Children's Legal Services' attorneys.

The child welfare practice model describes engagement in the following way:

- Build rapport and trust with the family and people who know and support the family.
- Empower family members by seeking information about their strengths, resources and proposed solutions.
- Demonstrate respect for the family as the family exists in its social network, community and culture.

The pre-service curricula is based on the key practices outlined in the practice model, the themes of relationship-building, respect for the family, and understanding the family's culture are woven throughout the curricula. Also, there is discussion about personal bias and understanding its impact on the work of the child welfare professional. Presenting these themes to child welfare professionals at the beginning of their employment with the Department sets a tone of respect and appreciation for all individuals involved in the child welfare system. It increases employee awareness of foster parents as partners and

professionals, thereby enhancing communications and relationships and improving recruitment and retention of valued members of our system of care.

In addition to "culture" being woven throughout, the pre-service "core curriculum" contains the following in module 4:

"Unit 4.2: The Impact of Family Dynamics and Culture on Family Functioning

- The purpose of this unit is to introduce to participants the concepts of family dynamics and culture. During this segment, participants will understand family dynamics and cultural characteristics, and will be provided opportunities to evaluate these elements through a scenario-based activity, and explain the dynamic they observe. This understanding helps participants approach their child welfare work with the ability to discriminate among healthy and unhealthy family dynamics and cultural issues."

The focus of pre-service training emphasizes to new child welfare professionals that respect and appreciation for differing family dynamics allows for meaningful engagement. Engaging families will allow workers to address to the issues that cause these families to become involved with Florida's system of care.

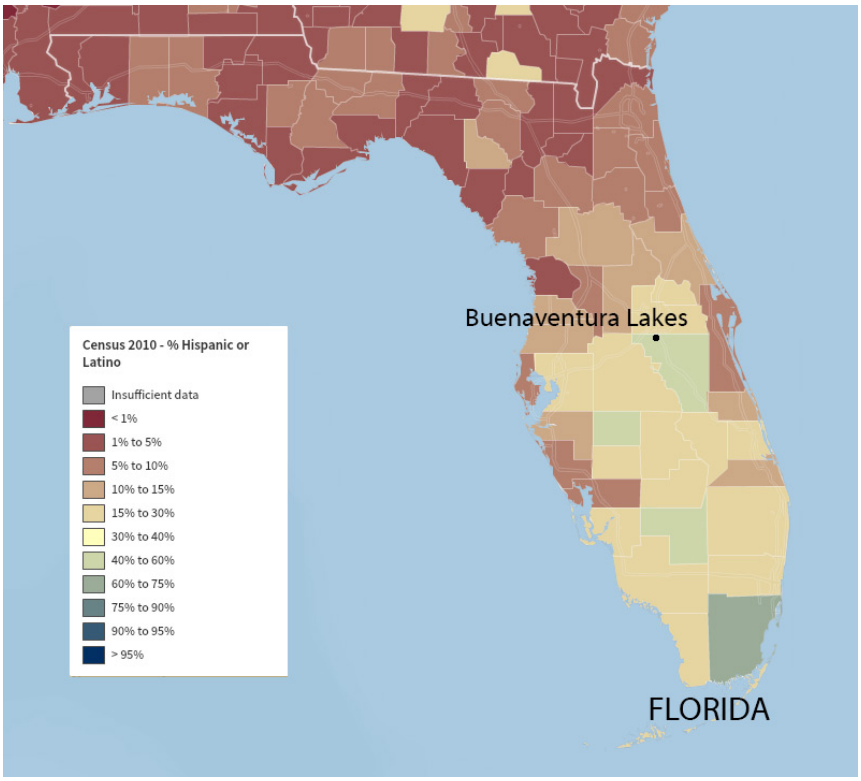
Strategies for dealing with barriers to communication

One strategy the Department will continue to use in order to address linguistic barriers is hiring staff from diverse backgrounds to ensure native speakers of Spanish, Creole, and other languages are available. Child welfare materials are available in Spanish and Creole, the two languages most used by families involved with the Department. In addition, interpreter services are available for purchase as needed. The chart below represents the primary languages spoken in Florida:

RANK	LANGUAGE	SPEAKERS
1	English	11,569,740
2	Spanish	2,476,500
3	French Creole	208,485
4	French	125,445
5	German	89,575
6	Italian	67,255
7	Portuguese	54,710
8	Tasalog	38,440
9	Arabic	32,420
10	Vietnamese	30,960

Source: Communicaid, http://www.communicaidinc.com/a-42-florida.php

Some areas of the state provide foster and/or adoption preparation classes in Spanish. The need for Spanish materials is greatest in areas south of Orlando, as indicated by the percentages of Hispanic or Latino populations in the map below.



(Source: 2010 U.S. Census).

In addition, providers have created some and are working to create more materials in French-Creole.

Linguistic barriers are not limited to the language spoken by a family. These barriers also can be hearing or speech limitations. The Department is partnering with Health and Human Services on an Advisory Committee for the Deaf and Hard of Hearing (DHH) to make improvements in the following areas, based on the committee's recommendations:

- Recruiting foster parents who are DHH or who can sign;
- Placing children in foster homes with parents who are DHH or who can sign, when appropriate;
- Ensuring caregivers who have a DHH placed in their homes receive appropriate aids and services; and
- Improving foster parent training as it relates to services to those who are DHH.

Non-discriminatory Fee Structures

The Department will continue to ensure that fees, if charged, are fully disclosed and defined in an impartial manner.

- All out-of-home care and adoption services are available free-of-charge.
- Prospective adoptive families may choose to pay for an adoption home study to expedite the process. If a family chooses to go to an outside agency that can conduct adoptive home studies

because they do not want to wait, they can choose to do so. Chapter 65C-16, Florida Administrative Code, determines in the order in which home studies are to be completed. The cost for securing a home study by this method ranges from $500 to $1500, depending on whether the family also attends adoptive parent pre-service classes and whether the individual completing the home study is a licensed practitioner, or attached to a licensed child placing agency.

- Florida Administrative Code 65C-15.010 governs "Finances" for child-placing agencies and provides a structure to ensure fees are based on reasonable costs and are non-discriminatory.

Timely Search and Placement

The Department, in collaboration with the Casey Family Programs, will continue the Permanency Roundtable model during the next five years. Training and mentoring by Casey Family Programs is provided for staff and stakeholders at each new site with a designated lead and facilitator identified by the new Community-based Care Agency. A monitoring component is in place to ensure fidelity to the model. Each new Community Based Care Agency begins their Permanency Roundtable implementation with a comprehensive review of all children who have an APPLA goal and children who have been permanently committed to the Department for more than 12 months. The goal is to implement the Permanency Roundtables statewide. Each year, one to two CBC lead agencies will develop an implementation plan that begins with a training plan and identification of one staff person from an experienced CBC assigned as a mentor. For additional information refer to Chapter II under Out of Home Care, APPLA and local permanency initiatives.

In addition, the Department's attorneys with Children's Legal Services, in collaboration with Casey Family Programs, will continue the "Cold Case" initiative and research cases that involve children who have been in care for three or more years.

All children available for adoption and who have no identified family must be, according to Florida statute, on the statewide website with a photo and narrative within 30 days of TPR. In addition, the national photo listings at adoption.com, adoptuskids.com and Children Awaiting Parents are utilized.

The Department will continue to collaborate with One Church One Child in efforts to recruit adoptive families for foster children by engaging local churches across Florida. The focus of One Church One Child is to continually reach out to the African American community. African American children represent about half (40 – 50%) of the available children awaiting adoption. In addition, One Church One Child provides education and outreach about the adoption process in the church community. This outreach is primarily to provide public awareness, support children in need of a permanent family, support foster/adoptive families, and keep the community involved and engaged. It is difficult to quantify the number of adults who become mentors, foster or adoptive parents, or supportive adults to someone in their church due to the time spans between outreach, response and training.

Additional child specific recruitment efforts are conducted for National Adoption Month in November and December and again for Black History Month in February. A video of an available child, primarily a teen, is shown each day in November, December and February on the statewide website at www.adoptflorida.org. The recruitment event is called "30 Days of Amazing Children" and each video will show a child speaking directly to the camera about topics important to him/her. During February, only

videos of the African American available children are shown. These recruitment efforts have resulted in increased numbers of inquiries to the Department's Adoption Information Center, 1-800-96-ADOPT.

The statewide Association of Heart Galleries completes annual child specific recruitment initiatives for 30 days. The event generate numerous inquiries and interest to 1-800-96-ADOPT.

Currently, the Dave Thomas Foundation's Wendy's Wonderful Kids program has Wendy's recruiters in eight CBCs. Wendy's Wonderful Kids in collaboration with the Department will be conducting a Post Adoption Study with children adopted through the recruitment efforts of Wendy's Wonderful Kids.

The Department's Adoption Specialist will continue to collaborate with the staff of Children's Medical Services and establish a written protocol that will allow the local Heart Gallery photos and videos of children with medical challenges to be on display in the CMS waiting rooms where the caregivers of children with similar medical issues congregate. This is an excellent target audience for children with medical challenges.

Plan for Action

Adoption

1. The Department, in collaboration with the Casey Family Programs, will engage at least one new Community Based Care Agency each year to join the Permanency Roundtable Project. Beginning in 2015, one to two CBCs will be implementing Permanency Roundtables each year.

During the report period, the Department, in collaboration with the Casey Family Programs, has implemented Permanency Roundtables in one additional CBC.

2. Once a month, the Department pulls information from Florida's statewide website to update the information about Florida's children on the national website, adoption.com. The information includes photo, age and web memo narrative for each child/sibling. This is an opportunity for Florida's children to be shown on another national website for recruitment (not analytic).

3. The Department's Adoption Specialist will continue to conduct a monthly monitoring of the children who are available without an identified family, according to FSFN, and are not on the statewide website. The Adoption Specialist will also communicate with the adoption specialist of each Community Based Care agency about the accuracy of the website.

4. The Department will continue to assess the tasks required in the contract for One Church One Child. For the upcoming year, the tasks will include:

- Recruitment and referral of 100 families to complete adoptive parent training
- Enrollment of 88 partner churches to assist with adoptive parent recruitment
- Six statewide educational presentations with churches about recruitment.

5. The statewide Association of Heart Galleries has a goal for the next five years to establish one or two annual child specific recruitment initiatives, especially a Heart Gallery display on the 22nd floor of the State Capital building, a well-trafficked area, to kick-off National Adoption Month. The plan will engage all fifteen Heart Galleries. In addition, the statewide Association will develop an action plan to assist the

local Heart Galleries disseminate and publicize the videos that are currently available on the 15 individual websites.

6. The Department's Adoption Specialist and the Wendy's Wonderful Kids Director will establish an action plan to engage more CBCs, with a focus on the need for Wendy's recruiters in the larger Florida counties. The goal will be to obtain at least one new Wendy recruiter per year for each of the five years.

7. The Department's Adoption Specialist will continue to collaborate with the staff of Children's Medical Services (CMS) to ensure that at least one CMS office per CBC displays local Heart Gallery photos and videos of children with medical challenges in the CMS waiting rooms.

Fostering

1. The Department will continue Fostering Success Priority of Effort to produce a "best practices" for foster parent recruitment.

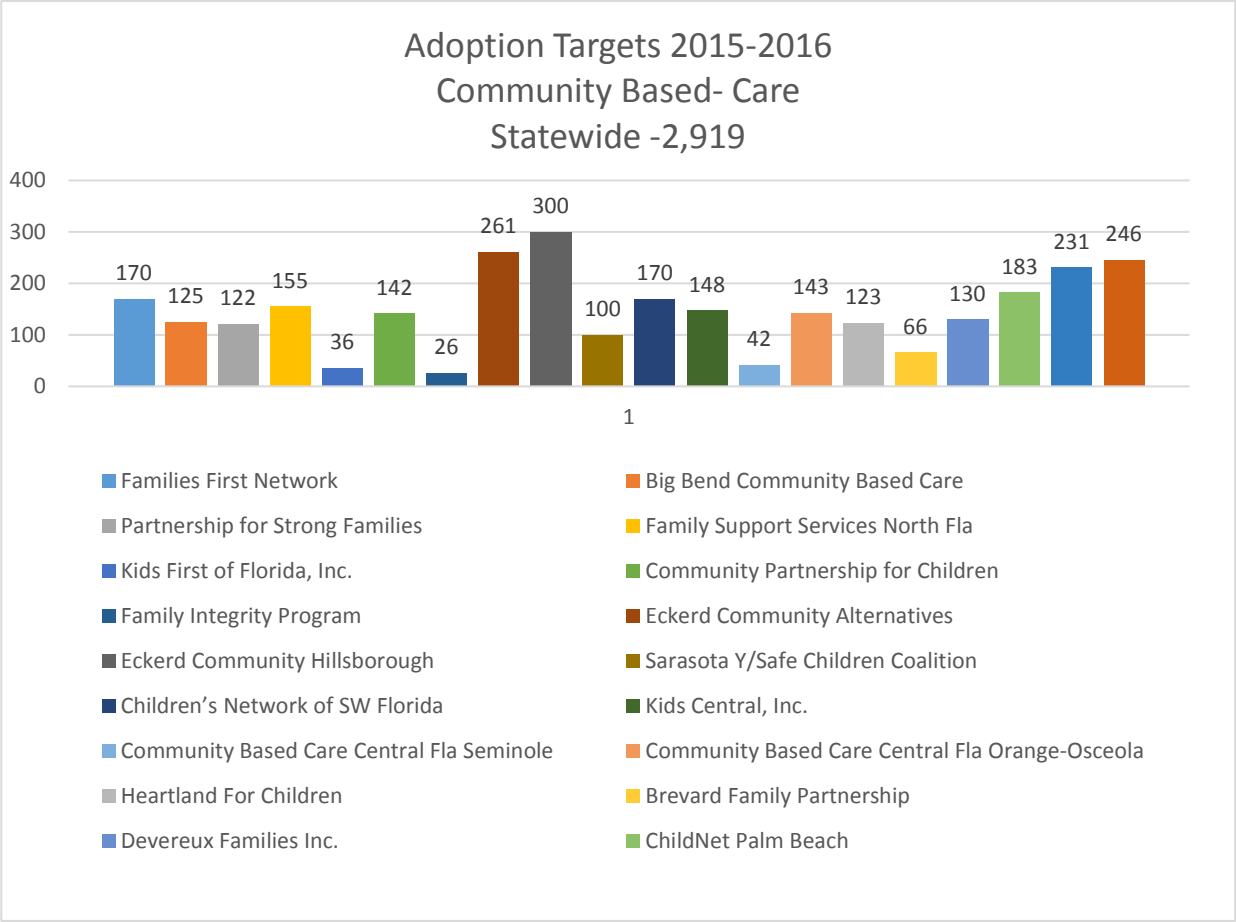
2. Work collaboratively with Community-based Care lead agencies and Department's Regional Managing Directors to analyze each local geographic region. Allow each CBC the ability to establish innovative strategies to establish foster home goals that are relevant for each community's system of care.

3. Continue to partner with the Quality Parenting Initiative and the FSFAPA to continue to support and provide resources for the quality foster parents around the state.

4. Continue making changes to Florida's administrative rule for foster home licensing to reduce barriers and unnecessary regulatory processes.

The Department and its community-based care partners goal is to reduce the number of children residing in group care by encouraging more families to foster and adopt children in foster care with special needs. Given the chance to live in a loving, nurturing home with a foster or adoptive family, these children often thrive and can achieve their maximum potential.

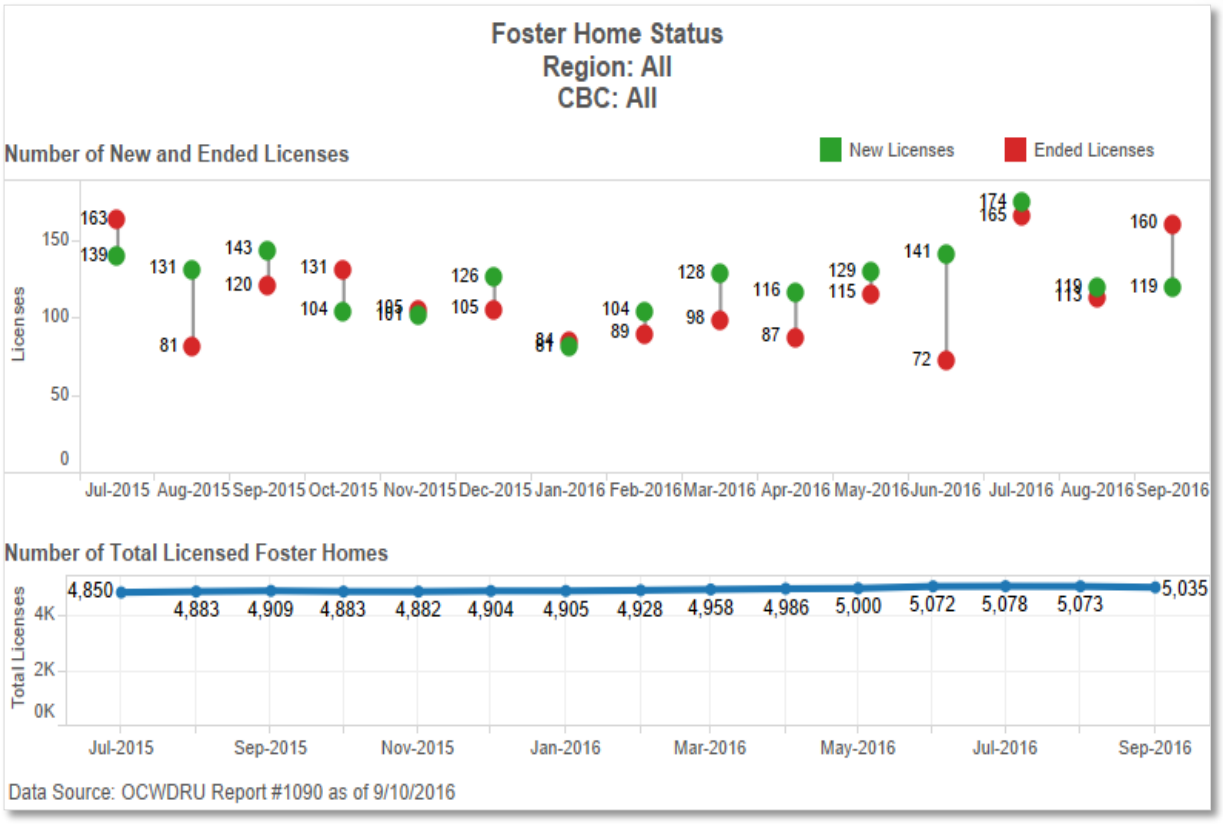
Adoption Targets



Counts of Licensed Foster Care Providers and Newly Licensed Providers

Table 1 **(Source: ad hoc analysis of FSFN data)**

Number of Licensed Foster Care Providers Statewide & Turnover	
Number licensed on 6/30/2015	4861
Number licensed on 6/30/2016	5072
Number licensed on 9/30/2016	5044
Number of Licenses Ended in SFY 2016/2017 as of 9/30/2016	444
Number of "newly licensed' in SFY 2016/2017 as of 9/30/2016	412


Foster Home Status
Region: All
CBC: All
Number of New and Ended Licenses
New Licenses
Ended Licenses
Licenses
150
100
50
0
163
139
131
81
143
120
131
104
126
105
104
89
128
98
116
87
129
115
141
72
174
165
160
119
Jul-2015
Aug-2015
Sep-2015
Oct-2015
Nov-2015
Dec-2015
Jan-2016
Feb-2016
Mar-2016
Apr-2016
May-2016
Jun-2016
Jul-2016
Aug-2016
Sep-2016
Number of Total Licensed Foster Homes
Total Licenses
4K
2K
0K
4,850
4,883
4,909
4,883
4,882
4,904
4,905
4,928
4,958
4,986
5,000
5,072
5,078
5,073
5,035
Jul-2015
Sep-2015
Nov-2015
Jan-2016
Mar-2016
May-2016
Jul-2016
Sep-2016
Data Source: OCWDRU Report #1090 as of 9/10/2016

Number of Licensed Providers, by CBC

Table 2 (Source: ad hoc analysis of FSFN data)

CBC	6/30/2015	6/30/2016	9/30/2016	Net Change from 6/30/2015 - 6/30/2016
Big Bend CBC	191	209	200	18
CBC of Brevard	113	132	129	19
CBC of Central Florida	217	235	238	18
CBC of Central Florida (Seminole)	87	96	94	9
ChildNet, Inc.	553	566	547	13
ChildNet Palm Beach	289	306	293	17
Children's Network of SW Florida, Inc.	359	377	376	18
Community Partnership for Children	183	193	194	10
Devereux CBC	140	172	178	32
Eckerd Community Alternatives	454	452	454	-2
Eckerd Community Hillsborough	403	419	401	16
Families First Network	311	298	299	-13
Family Integrity Program	47	47	48	0
Family Support Services of North Florida	352	363	372	11
Heartland for Children	181	180	184	-1
Kids Central, Inc.	189	205	218	16
Kids First of Florida, Inc.	66	88	86	22
Our Kids of Miami-Dade/Monroe, Inc.	406	425	430	19
Partnership for Strong Families	131	148	142	17
Sarasota Family YMCA, Inc.	160	150	152	-10
Unknown	**13**	**11**	**9**	-2
Total	**4845**	**5072**	**5044**	227

Number Newly Licensed between 7/01/2014 and 9/30/2015, by CBC

Table 3 (Source: ad hoc analysis of FSFN data)

CBC	Number of Newly Licensed Foster Homes	Total Bed Capacity of Newly Licensed Foster Homes	Number of Newly Licensed Foster Homes with a New Placement After Licensure**	Percent of Newly Licensed Providers with a New Placement Since Licensed
Big Bend CBC West	76	133	62	82%
CBC of Brevard	60	97	43	72%
CBC of Central Florida	158	256	115	73%
CBC of Central Florida (Seminole)	98	143	79	81%
ChildNet, Inc.	109	185	77	71%
ChildNet Palm Beach	76	121	56	74%
Children's Network of SW Florida, Inc.	21	33	19	90%
Community Partnership for Children	56	98	40	71%
Devereux CBC	73	102	55	75%
Eckerd Community Hillsborough	105	168	88	84%
Eckerd Youth Alternatives, Inc.	128	223	103	80%
Families First Network	87	170	77	89%
Family Integrity Program	13	32	12	92%
Family Support Services of North Florida	102	210	77	75%
Heartland for Children	53	115	46	87%
Kids Central, Inc.	67	137	54	81%
Kids First of Florida, Inc.	42	85	25	60%
Our Kids of Miami-Dade/Monroe, Inc.	107	205	94	88%
Partnership for Strong Families	46	87	36	78%
Sarasota Family YMCA, Inc.	24	38	22	92%
Unknown	**1**	**2**	**0**	**0%**
Total	**1502**	**2640**	**1180**	**79%**

Attachment A to Appendix B

Florida Intelligent Recruitment Project Information

Project Description: Building upon Fostering Florida's Future, a statewide collaborative effort designed to improve the quality and availability of foster and adoptive resource homes, the Department of Children and Families (DCF) proposed to implement an intelligence-driven approach to the diligent and targeted recruitment of families for children in the foster care system. Utilizing Gold & Associates' "*Intelligent Imagination*"™— a value- and behavior-based multi-layered strategic marketing process deployed for Disney, GEICO, the NFL and many other Fortune 500s firms, the *Intelligent Recruitment Project* (IRP) committed to breaking 'plateaus' of child placement.

The project team, consisting of the Florida Department of Children and Families and four privatized child welfare Community Based Care Lead Agencies, each responsible for coordinating child welfare safety and permanency services in one or more Judicial Circuits, is focused on using proven marketing strategies to identify permanent resource families for some of Florida's most difficult to place youth. The project proposal, theory of change and logic model emphasized the implementation of the *Intelligent Recruitment Project* as a means to improve permanency outcomes for children in 21 Florida Counties; utilizing a level of creativity that doesn't always occur in the child welfare system.

The approach builds upon key findings from 2008 and 2010 Diligent Recruitment grantees and serves as a national 'test-bed' for measuring the effectiveness of a strategic market research-based approach to recruiting across distinct demographic, geographic, and socioeconomic environments.

Responsibility Matrix:

Entity	Responsibilities and Timeframe (Task or Activity)
Florida Department of Children and Families (DCF)	Project Kickoff • Execute and maintain contract with ACF / Children's Bureau • Convene project partners, clarify roles and responsibilities, execute sub-contract with Kids Central as Managing Partner Year One Specific Tasks • Participate in scheduled project partner meetings • Collaborate in the development of project plan and communication plan • Review and approve revised project plan for years 2 – 5 • Provide access to needed data for development of Strategic / Targeted Marketing research and planning Ongoing Project Responsibilities Years 2 - 5 • Submit semi-annual reports compiled by Kids Central and project partners • Review and submit annual budget completed by Managing Partner (Kids Central) • Monitor annual project plan and reported outcomes and make recommendations for changes to schedule, activities, or

Entity	Responsibilities and Timeframe (Task or Activity)
	• Identify and provide recommendations related to project implementation and progress in relation to statewide initiatives, strategic goals and objectives • Identify and mitigate potential barriers to dissemination at the statewide level • Integrate and communicate project work and findings state wide through *Fostering Florida's Future* workgroup and meetings • Integrate findings into statewide Child and Family Services Plan • Provide access to child services data (via SACWIS) in accordance with each Community Based Care Lead Agency contract • Provide necessary staffing and associated funding required to complete project activities.
Kids Central, Inc. (Project Managing Partner)	Managing Partner Responsibilities: 1. Provide all aspects of grant management including, 2. Develop annual project plan including activities, work schedules, key deliverable due dates, and outcome expectations, 3. Monitor adherence to work plan 4. Establish annual budget 5. Schedule and facilitate project meetings 6. Initiate project communication 7. Maintain project communication forums (web, blog, written communication) 8. Compile materials and tools developed for project tasks 9. Establish and maintain website for project documentation 10. Develop, monitor and amen d project annual budget as necessary 11. Collect and compile documentation from each project partner pertaining to work activities, budget expenditures, progress towards project activities, goals and objectives 12. Work collaboratively with project partners to refine and implement project plan for years 2 - 5 13. Compile semi-annual reports and provide to DCF for submission 14. Monitor evaluation activities and outcomes, amend project plan, activities and schedule as appropriate 15. Provide all necessary oversight and communicate feedback to project partners 16. Coordinate attendance and presentations at annual Grantees Meeting 17. Collaborate with and provide project information, data, and findings to DCF Project Kickoff • Convene project kick off in partnership with DCF • Develop project charter in cooperation with partnering entities Year One Specific Tasks • Work collaboratively with Gold and Associates to develop market data collection tools, collect data, compile data, and interpret results • Revise years 2 – 5 project plan based on year 1 findings and outcomes • Provide oversight of project subcontractors, *Gold and Associates* and *J.K. Elder & Associates* • Develop and execute project communications plan with partnering entities • Review specific geographic and programmatic areas of need for children in care • Provide Gold and Associates and J.K. Elder & Associates with required Circuit-level (via SACWIS or internal tracking systems) • Collaborate with external evaluator to develop evaluation plan and IRB application

Entity	Responsibilities and Timeframe (Task or Activity)
	• Develop circuit-specific strategic targeted marketing plan in cooperation with, and in consideration of recommendations and findings made by Gold and Associates • Submit revised Years 2 – 5 Plan for ACF review and approval Ongoing Project Responsibilities Years 2 - 5 • Provide required staffing to implement strategic targeted marketing plan • Implement strategic targeted marketing plan • Re-allocate CBC contractual funding to fund media campaign created in collaboration with Gold and Associates • Attend project meetings • Maintain local project communication plan with key stakeholders • Modify circuit-level project activities in response to evaluation findings and project outcomes • Attend all project meetings • Designate project staff to attend annual grantee meetings • Provide necessary staffing and associated funding required to complete project activities.
Big Bend CBC, Inc. Heartland for Children, Inc. Our Kids of Miami-Dade / Monroe, Inc.	Project Kickoff • Attend project kickoff meeting • Collaborate with project partners to develop project charter, communication plan and work plan Year One Specific Tasks • Review specific geographic and programmatic areas of need for children in care • Work collaboratively with Gold and Associates to develop market data collection tools, collect data, compile data, and interpret results • Revise years 2 – 5 project plan based on year 1 findings and outcomes • Develop and execute project communications plan with partnering entities • Provide Gold and Associates and J.K. Elder & Associates with required Circuit-level (via SACWIS or internal tracking systems) • Develop circuit-specific strategic targeted marketing plan in cooperation with, and in consideration of recommendations and findings made by Gold and Associates • Provide required staffing to implement strategic targeted marketing plan Ongoing Project Responsibilities Years 2 - 5 • Implement strategic targeted marketing plan • Re-allocate CBC contractual funding to fund media campaign created in collaboration with Gold and Associates • Attend project meetings • Maintain local project communication plan with key stakeholders • Modify circuit-level project activities in response to evaluation findings and project outcomes • Attend all project meetings • Designate project staff to attend annual grantee meetings
Gold and Associates, Inc.	Project Kickoff • Attend project kick off meeting • Work collaboratively with all partners to establish project work plan

Entity	Responsibilities and Timeframe (Task or Activity)
	Year One Specific Tasks • Review specific geographic and programmatic areas of need to establish data collection process • Prepare strategic targeted marketing process overview and present to project partners • Develop forms, questionnaires, focus group protocols and interview protocols to collect demographic, geographic, and lifestyle data from current foster parents • Prepare a statistical research questionnaire • Prepare outreach materials explaining data collection purpose and process for distribution to foster / adoptive resource families • Execute market research plan / statistical study • Present findings • Coordinate and cross-reference data using proprietary systems to identify market-specific trends for successful outreach in each distinct market area • Develop strategic targeted marketing plan with recommendations for messaging, media, formatting, and frequency (as appropriate) Ongoing Project Responsibilities Years 2 - 5 • Work collaboratively with CBC Lead Agencies to implement and execute marketing plans
J.K. Elder & Associates, Inc. (External Evaluator	Project Kickoff • Attend project kick off meeting • Work collaboratively with all partners to establish project work plan Year One Specific Tasks • Design project logic model • Review and refine appropriate control group • Design and implement project evaluation plan • Review project work plan, charter, and other documentation for compliance with project objectives, intent and desired outcomes – provide recommendations to project partners • Communicate data needs, timeframes and submission requirements to project partners • Develop evaluation tools, questionnaires, surveys, focus group questions, protocols, process documentation, formats and data bases to capture project data to evaluate implementation and outcomes • Submit IRB Application and annual updates Ongoing Evaluation Tasks Years 1 - 5 • Implement data collection protocols • Compile project data from each partnering CBC Lead Agency • Document project qualitative and quantitative changes for process and outcome aspects of evaluation • Data analysis and reporting • Provide monthly status report and related recommendations • Complete semi-annual project evaluation reports and submit to project partners for review and submission to ACF

Entity	Responsibilities and Timeframe (Task or Activity)
	• Compile and communicate project findings with each partnering agency, statewide workgroup (via DCF), and provide recommendations for integration into Child and Family Services Plan • Attend annual grantee meeting • Provide staffing required to execute and implement project evaluation tasks and objectives.

Target Analysis: CBC Lead Agencies serve more than 5,200 children who have been in out-of-home care for more than 12 months. The project is specifically designed to respond to the most challenging of these cases; those who are from nine (9) to fifteen (15) years old. The project continues to cover six Judicial Circuits (21 counties) and includes children from a broad range of socioeconomic, ethnic, and demographic characteristics. The large, diverse population of children served by the partnering agencies supports the selection of a representative target population that serves as the focus for our project. The following charts provide a breakdown of these youth by CBC Lead Agency in 2016:

CBC Lead Agency	Total # of Youth in Target Population	9	10	11	12	13	14	15	M	F	Average Time Since Removal (Years)	Average Time Since TPR (Years)
BBCBC	37	3	2	4	2	4	7	2	10	3	19	2.6
HFC	25	1	2	2	1	2	3	6	4	4	15	3.6
KCI	35	3	2	4	5	1	2	6	9	3	20	3.5
Our Kids	104	6	10	8	12	12	12	14	21	9	63	4.1

Projected Need: Given existing removal, placement and recruiting trends, the project team projected potential needs for each Lead Agency partner. Additionally, CBCs were initially asked to independently project their targeted recruitment goals based on their perceived need. The following table provides the initial comparison of calculated need vs. independent projections for each CBC:

CBC Lead Agency	Calculated Needs Projection	CBC Recruitment Target
Big Bend CBC	42	119
Heartland for Children	72	70
Kids Central, Inc.	53	60
Our Kids Inc.	154	195

Project Status: The participating CBC partners have intensified implementation of customized marketing plans which were developed through a stratified marketing and recruitment approach base. The project partners developed two workgroups to assess and influence the impact of customer service and concurrent planning on their systems of care.

IRP data from April 2016 – August 2016 stated that the average number of years from TPR has reduced from 5.33 to 2.55.

FL-IRP Population Quick View

	Semi-Annual Period Ending					Project Total
All FL-IRP Partner Locations	**9/30/2014**	**3/31/2015**	**9/30/2015**	**3/31/2016**	**9/30/2016**	
Population (N) at Start of Period	-	104	117	209	186	
Demographics of Youth Entering Population						
# Youth Entering Population During Semi-Annual Period	107	32	119	35	52	293
Average Age of Youth Entering Population	13.24	12.84	12.25	12.03	12.42	12.62
Gender of Youth Entering Population: # and % (M / F)	67 (62.62%) / 40 (37.38%)	18 (56.25%) / 14 (43.75%)	61 (51.26%) / 58 (48.74%)	21 (60.00%) / 14 (40.00%)	30 (57.69%) / 22 (42.31%)	197 (67.24%) / 148 (50.51%)
Youth Entering Population with Multiple Removals	42 (39.25%)	12 (37.50%)	54 (45.38%)	13 (37.14%)	21 (40.38%)	142 (48.46%)
Youth Entering Population Prescribed Psy Meds	50 (46.73%)	16 (50.00%)	39 (32.77%)	10 (28.57%)	18 (34.62%)	133 (45.39%)
Demographics of Youth Achieving Permanency						
# Achieving Permanency	3	19	27	58	36	143 (48.81%)
Average Age at Time of Permanency	11.99	13.79	12.67	12.14	12.69	12.60
Gender of Youth Achieving Permanency: M/F (# & %)	2 (66.67%) / 1 (33.33%)	10 (52.63%) / 9 (47.37%)	14 (51.85%) / 13 (48.15%)	35 (60.34%) / 23 (39.66%)	18 (50.00%) / 18 (50.00%)	79 (55.24%) / 64 (44.76%)
Youth with Prior Removals Achieving Permanency (# & %)	0 (0.00%)	7 (36.84%)	12 (44.44%)	25 (43.10%)	16 (44.44%)	60 (41.96%)
# & % of Youth Achieving Permanency Prescribed Psy. Meds	2 (66.67%)	3 (15.79%)	10 (37.04%)	14 (24.14%)	13 (36.11%)	42 (29.37%)
Average Years from Removal to Permanency	2.53	3.95	4.18	3.13	3.45	3.51
Average Years from TPR to Permanency	5.33	3.29	2.37	4.32	2.55	3.39
Average Years from Population Entry to Permanency**	0.00	0.21	0.46	0.33	0.75	0.44
Demographics of Population at End* of Semi-Annual Period						
# Youth in Population at End of Period	104	117	209	186	202	
Average Age of Youth in Population at End of Period	13.32	13.53	13.19	13.84	14.13	
Gender of Youth in Population at End of Period: M/F (# & %)	65 (62.50%) / 39 (37.50%)	73 (62.39%) / 44 (37.61%)	120 (57.42%) / 89 (42.58%)	106 (56.99%) / 80 (43.01%)	118 (58.42%) / 84 (41.58%)	
# and % of Youth With Prior Removals Remaining in Population	42 (40.38%)	47 (40.17%)	89 (42.58%)	77 (41.40%)	82 (40.59%)	
# & % Youth Prescribed Psy Meds Remaining in Population	48 (46.15%)	61 (52.14%)	90 (43.06%)	86 (46.24%)	91 (45.05%)	
Youth Entering this Period who have Achieved Permanency						
# of Youth Entering this Period Achieving Permanency	43	20	62	15	3	
% of Youth Entering this Period Achieving Permanency	40.19%	62.50%	52.10%	42.86%	5.77%	
Average Age at Time of Permanency	13.55	12.96	12.05	12.29	9.17	
Average Years from Removal to Permanency	4.58	3.31	3.04	2.60	3.60	
Average Years from TPR to Permanency	3.61	1.90	4.29	1.28	2.02	
Average Years from Population Entry to Permanency*	0.63	0.55	0.37	0.14	0.07	

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Appendix C.

Florida's Health Care Oversight and Coordination Plan

Florida's Health Care Oversight and Coordination Plan

Florida's Health Care Oversight and Coordination Plan is a discreet plan within Florida's Child and Family Services Plan 2015-2019. The link for the CFSP and full Health Care Oversight and Coordination Plan on Florida's Center for Child Welfare is

http://centerforchildwelfare.fmhi.usf.edu/Publications/ChildFamilyServicesPlan.shtml

Update

During the reporting period, the Department collaborated with the Agency for Healthcare Administration (AHCA) regarding the Child Welfare Specialty Plan through ACHA's Managed Medical Assistance (MMA) program. The Managed Medical Assistance (MMA) program provides primary care, acute care, and behavioral health care to recipients enrolled in an MMA plan. The following are updates to the Health Care Oversight and Coordination Plan.

Continuity of Care and Coordination of Services

Health Care and Behavioral Health

The Child Welfare Specialty Plan provides care coordination/case management appropriate to the specific needs of child welfare recipients. The plan is required to develop, implement, and maintain a care coordination/case management program specific to the child welfare specialty population, approved by Agency for Health Care Administration (AHCA). In addition, the plan requires submission of a care coordination/case management program description annually to the Agency for Health Care Administration. The care coordination/case management program description shall, at a minimum, address:

(1) The organization of care coordination/case management staff, including the role of qualified and trained nursing, social work and behavioral health personnel in case management processes;

(2) Maximum caseload for case managers with an adequate number of qualified and trained case managers to meet the needs of enrollees;

(3) Case manager selection and assignment, including protocols to ensure newly enrolled enrollees are assigned to a case manager immediately.

AHCA has developed performance measure to ensure the health care needs of children are being met. AHCA will monitor performance through the contract performance measures required within the Child Welfare Specialty Plan contract. AHCA has adopted a set of quality metrics that sets targets on the metrics that equal or exceed the 75th percentile national Medicaid performance level. In addition, these metrics will be used to establish plan performance, improvement projects focusing on areas such as improved prenatal care and well child visits in the first 15 months and better preventive dental care for children. The Child Welfare Specialty Plan must report on 24 measures from the Healthcare Effectiveness Data and Information Set (HEDIS), 6 measures from the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measures, 11 measures that are agency defined, 2 measures that are HEDIS and agency defined, and one Joint Commission measure. The list of performance measures that

the Child Welfare Plan is required to report and the report card on these measures can be found in the Report Guide at the following link:

http://ahca.myflorida.com/medicaid/statewide_mc/report_guide_2015-07-01.shtml

AHCA has developed a Medicaid Health Plan report card to help provide consumers with information about the quality of their Medicaid health plans. The report card, based on the above performance measures, gives consumers valuable information on the performance of their plan and other available plans. This data includes performance measures for the Child Welfare Specialty Plan. The health plan report card is based on 2014 performance data for health plans that are now operating under the Managed Medical Assistance (MMA) program and includes data related to the following five performance measure categories:

1. Pregnancy-related Care
2. Keeping Kids Healthy
3. Keeping Adults Healthy
4. Living with Illness
5. Mental Health Care

The Florida Health Plan report card can be found at the following link:
http://www.floridahealthfinder.gov/HealthPlans/Search.aspx?p=5

Medical and Dental Services
Performance indicators for psychotropic medication and dental services in the last 7 months is provided monthly through the Monthly Key Indicator Report.
http://centerforchildwelfare.fmhi.usf.edu/qa/cwkeyindicator/KI_Monthly_Report_March_2017_Final.pdf
There are summary reports in FSFN to track this, and corresponding list reports that have allowed caseworkers and managers to identify children who have not had these services in the requisite time frame, or are coming due for a service.

Psychotropic Medication Oversight and Monitoring

There are a number of laws, administrative rules and policies that govern the administration and monitoring of psychotropic medication use. The Department works in conjunction with AHCA to provide extra levels of oversight and monitoring. AHCA had expanded the prior authorization requirements for filling prescriptions for certain medications. Prior authorizations include a review of the child and medication by a child psychiatrist with the University of South Florida, and is required in the following circumstances:

- Antidepressants (Age <6 years)
- Antipsychotic (Age <6 years of age)
- Antipsychotic (Age 6 to < 18 years of age)
- Stimulants and Strattera (<6 years of age)

In an effort to reassess the effectives of administrative rule and operating procedures governing the use of psychotropic medications, the Department convened a workgroup to review the psychotropic medications process and to implement improvements. The workgroup began meeting in late July 2015. The group consists of stakeholders from across the child welfare spectrum including the Department of Health, AHCA, University of Florida, CBCs, and the Guardian Ad Litem Program as well as others. The varying expertise on the group provides for an opportunity to assess the effectiveness of current processes and make recommendations for long-term sustainable solutions in the identified areas of rule, policy and training.

Updates and Accomplishments

- Amended Chapter 65C-35, Florida Administrative Code, effective April 20, 2017. The changes involve in-depth oversight and additional efforts from child welfare professionals, Children's Legal Services, and prescribing practitioners.
- Reconvened the psychotropic medication workgroup in April 2017 to address the effectiveness of the current process.

Future Plans

- Review the current Med Consult line to decide whether to if widen the scope of the population receiving pre-consent reviews. If recommended, this will allow all children in out-of-home care to have their psychotropic medication treatment plans reviewed by University of Florida (UF) child psychiatrist to ensure medications prescribed are in accordance with the best practice.
- Continue the psychotropic medication workgroup's review of the effectiveness of the current process specific to psychotropic medication and make modification as recommended.

Trauma-Informed Care

The Department completed activities to implement policy and procedure in accordance with the 2015 amendments to Florida Statutes that address the rising rate of Human Trafficking amongst the child welfare population. The changes to Section 409.1754(1)(a) and 409.1678(7)(e), F.S., directed the Department to develop or adopt an initial screening or assessment tool to determine the appropriate placement for sexually exploited children and to provide specific training to be developed for foster parents and staff on the needs of sexually exploited children as well as the effects of trauma on these children.

Sharing Medical Information, With the Option for an Electronic Health Record

In 2013, the Florida Legislature appropriated $450,000 to create an electronic health records system for children in foster care. The Department contracted with Five Points to create this system using a system already in partial use in Florida called MyJumpVault. The system is available to all CBCs. The legislature funded the continued maintenance of the system for the 2015-2016 state fiscal year.

Healthcare Transition Planning for Youth Aging Out of Foster Care

In July 2014, community advocates notified the Office of Child Welfare that a large number of young adults served by DCF were not aware of their new eligibility for Medicaid. These young adults aged out prior to the extension of foster care and the Affordable Care Act, and are now over 21 years of age. In partnership with the Department's Automated Community Connection to Economic Self Sufficiency (ACCESS) Office, the Office of Child Welfare identified the population of young adults who had not applied for Medicaid. The Office of Child Welfare issued guidance and worked in partnership with Community-Based Care providers throughout the state to address this concern. All young adults participating in an Independent Living Program who are eligible will be enrolled during the 2014-2015 federal reporting period.

To continue monitoring Medicaid enrollment of youth who reached age 18 while in foster care but are not currently receiving Independent Living Services, the Department disseminated to the six DCF Regions the first quarterly list reflecting young adults ages 18-26 who reached age 18 while in foster care and their current Medicaid status. Lists will continue through the 2015-2016 reporting period.

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Appendix D.

Florida's Child Welfare Disaster Plan

Florida's Child Welfare Disaster Plan

Statewide Disaster Planning

As required, Florida's Child Welfare Disaster Plan is a discrete plan within Florida's Child and Family Services Plan (CFSP) 2015-2019. The link for the CFSP and full Child Welfare Disaster Plan on Florida's Center for Child Welfare is:

http://centerforchildwelfare.fmhi.usf.edu/Publications/ChildFamilyServicesPlan.shtml

Update

Florida experienced two (2) hurricanes during the October 2015 through September 2016 reporting year. Closures were minimal, and no locations were shut down for more than two (2) days. The Office of Child Welfare and the Office of General Services continue to be vigilant in communicating the need to review and revise, when necessary, all Emergency Plans from Community-Based Care lead agencies and their subcontracted providers. The Department also reminds stakeholders and partners in the field to make sure staff are trained and apprised of any changes in the plan. All information from Chapter IX, Florida's Child Welfare Disaster Plans, CFSP 2015-2019, remains relevant.

- Florida's privatization of child welfare case management services created Community-based Care lead agencies in each of the state's 20 judicial circuits. Each lead agency has locally driven Continuity of Operations Plans and Child Welfare Disaster Plans. The disaster plans address how the lead agency and any subcontracted case management agencies would assist families in maintaining uninterrupted services if displaced or adversely affected by a disaster. All written plans are updated and submitted annually to the Department of Children and Families. Copies of the written plans are provided to the Department of Children and Families' Office of General Services and Regional Contract Managers, and are made available to the circuits, regions and within all community-based care locations.
- In case of a disaster, one of the aftermath activities of local agencies responsible for case management services is to quickly begin to contact families who care for children under state custody or supervision. During these contacts, the child's case manager (primary case manager) explores if any services to the child have been interrupted by the disaster.
- The case manager will explore with the family the expected duration of interruption, alternative service providers, transportation considerations, etc.
- Local agencies make determinations of the extent of damage and interruption of services. If the agency identifies that certain services to children may be interrupted (such as speech therapy, mental health services, tutoring or other educational supports, etc.), the agency will work with local community providers and volunteers to address the provision of alternative services and ensure that the case manager supervisors inform staff of the alternative services available.
- If a family relocates intrastate due to a disaster, the child's primary case manager will request, through the Courtesy Supervision mechanism, that a secondary case manager be assigned in the new county. The secondary case manager will be responsible for conducting visits, identifying new needs based on the relocation, providing stabilization services to the family, and completing referrals that would ensure the child is provided services for previously identified needs. The

primary and secondary worker would also work together and with the local providers in their respective areas to ensure that new providers have current, relevant information about the child's needs and status in service provision prior to the child leaving his/her originating county.

- If the family relocates interstate, the primary worker will immediately notify the Florida Interstate Compact on the Placement of Children Office (ICPC) and will forward a packet of information to be sent to the receiving state so that notification and a request for services can be made. The packet will include a Child Social Summary that will contain information about service needs and will request that the assigned local case manager make contact with the child's Florida case manager to discuss service needs. The receiving state's case manager will be asked to initiate continued services to address the child's previously identified needs as well as any new needs identified based on the case manager's contact with the family.

The Department of Children and Families and its Community-based Care lead agencies will continue to work with state emergency management personnel and agency leadership to help ensure the safety of clients and staff prior to, during, and after any disaster that Florida may experience.

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Appendix E.

Florida's Training Plan

Updates to Florida's Training Plan

Section 2:
Headquarters Training Unit Overview, describes the growth of the Department's training unit in the Office of Child Welfare, starting on page 6.

Section 3:
Descriptions of the certification process which includes requirements for provisional certification, training caseloads, and full certification have been added beginning on page 7. The description of the initial training for new Child Welfare Professionals provides updated curriculum information on the Case Management Pre-Service Curriculum and Foster Parenting Licensing curriculum beginning on page 22.

Additions were made to the Children's Legal Services Pre-Service Curriculum beginning on page 30. The anticipated implementation dates for new or updated Pre-Service tracks for Core and Adoptions have been updated beginning on page 26.

Section 4:
Training Tracking, provides information on how the tracking of training events and courses has been updated, starting on page 38.

Section 5:
Training Funding, includes updates on the usage of Title IV-E funds for training, starting on page 39.

Additionally, the prior update concerning the Title IV-E student stipend training program has been amended and updated into Florida's staff development and training plan, starting on page 1.

Florida's Staff Development and Training Plan

Florida's Staff Development and Training Plan is located:
http://centerforchildwelfare.fmhi.usf.edu/Publications/ChildFamilyServicesPlan.shtml

Florida's Title IV-E Social Work Student Stipend Training Program

The Title IV-E Student Stipend Training Program leverages federal dollars at the 50% Federal Financial Participation rate to provide social work students with a specialized Title IV-E related course of study in child welfare retroactive to October 1, 2015. The Department in collaboration with the Florida Association of Deans and Directors of Social Work (Association) and a representative of the case management organizations developed a Social Work Student Recruitment Stipend Training Program for the State of Florida.

The Student Stipend Training Program was designed to ensure when students graduate with a degree in Social Work at one of the 14 public/private universities, they were prepared to pass the test for certification as a child welfare professional and to be employed as a case manager or child protective investigator without going through the weeks of pre-service core curriculum training. The testing for certification is administered upon employment. When this program was created the turnover rate for community-based care case managers was 30% (Source: Florida and Other States' Child Welfare Systems,

Office of Program Policy Analysis and Government Accountability); the turnover rate for child protective investigators was 40% (Source: DCF, Human Resources, Turnover Report). High turnover requires continuous recruitment and training of child welfare professionals. The Department and its contracted entities must sustain a multi-pronged approach to stabilize and professionalize the workforce.

Florida's program consisted of three parts. First and foremost was the stipend itself. The stipends were not to exceed $6,000 for a full-time student or $4,000 for a part-time student. Stipends were to be used by the student while attending a semester of school. Each student could receive a maximum of two stipends, one per state fiscal year. The stipend recipients must commit to work for the Department, or with a community-based care agency post-graduation on a year for year basis (meaning one year of receiving a stipend equates to one year of work). The stipend recipients must obtain employment within six months of graduating (full time employment). If a stipend recipient fails to fulfill the work commitment, the student must repay the stipend.

The stipend training program was designed to prepare social work students for employment in child welfare and assist in stabilizing the state's child welfare workforce. The students exiting the stipend training program were ready to begin work as a child protective investigator or in case management (in-home care, foster care, and adoptions) without going through the entire child welfare pre-service training program. The recipients completed a course of study that aligned with the five-week core child welfare pre-service curriculum as a part of their education through the Schools of Social Work.

Competencies emphasized included skills and abilities related to the following major job tasks: assessment, case planning, family centered practice, interviewing, and family preservation, ongoing assessment, removal, placement, permanency, and well-being. A recipient hired by the Department, or for case management service delivery (for in-home care, foster care or adoptions) by a community-based care agency, would have the necessary skills, including assessment skills, and be prepared to work with children and families.

Core curriculum is the first step for all employed as a child welfare professional with the Department and Community-Based Care organizations. The stipend recipient would be knowledgeable of:

- *child development*: child maturation, developmental stages, need for protection, nurturing and well-being;
- *trauma*: the short-and long-term impacts of traumatic events on the child, highlighting the importance of careful, thoughtful professional communication and intervention. Important facts about screening, assessing and evaluating trauma, as well as the importance of considering culture and historical trauma when approaching children and families in a trauma-informed manner;
- *family conditions*: family systems and the family dynamics that impact family functioning. The concepts of family dynamics and culture to help them approach their child welfare work with the ability to discern healthy and unhealthy family dynamics and cultural issues. A clear understanding of the impact of mental health issues on the families and the role of the child welfare professional in addressing such mental health issues in the family. A framework for understanding how poverty impacts the families with whom child welfare professionals work.

Child welfare-related implications of working with a family in which a caregiver has limited cognitive functioning;

- *child maltreatment*: maltreatment, including some specific types of maltreatment - neglect, physical abuse, sexual abuse, mental injury, dynamics of substance abuse, and the dynamics of domestic violence;
- *assessment and analyzing family functioning*: assessment of the six domains of information collection – Family Functioning Assessment; skill in writing critically-thought, synthesized assessments regarding the extent maltreatment and circumstances surrounding of maltreatment; broadens the focus beyond the child's developmental stages to look at the child's functioning needs within his or her family, including assessment and analysis; defines adult functioning and helps to understand what information constitutes adult functioning, as well as how to assess and analyze this information; to help participants understand the basic concepts associated with the Parenting General domain and understand why this information is important in the overall assessment of Family Functioning; and helps participants understand the Parenting Discipline;
- *safety and risk*: how child development, trauma, maltreatments, and family conditions create a safe or unsafe environment for children and whether a non-maltreating parent has the sufficient protective capacities to protect against the danger.

The time spent in pre-service training decreased significantly (five weeks) for the stipend recipients. The end state was to have a qualified and talented staff that possessed the required skill set for a child welfare professional upon graduation.

The second part of the program was the faculty who were involved with the stipend training program. Faculty were hired to work 100% for the stipend training program. Their job duties included working with the students, developing curriculum in conjunction with the Department and the Florida Institute for Child Welfare that addressed the core competencies, teaching specialized classes for the benefitting program, developing appropriate field settings in child welfare agencies, recruiting and selecting appropriate students to participate in the program, and acting as a mentor and coach for the students in the program.

Oversight and evaluation made up the third part of the program. Two full-time employees, one program lead and one administrative assistant, guide implementation, oversaw, and validated the program's required eligibility checks, reviews, screenings, federal requirements, and fulfillment of work commitments for the program.

The Department contracted with the University of Central Florida (UCF) as the coordinator for this program. This lead university coordinated with the 13 other participating schools of social work through sub-contracts. UCF had two full time and two part-time positions to administer the statewide program and coordinate among the other universities.

The full-time administrative coordinator was responsible for coordinating UCF's stipend program and oversaw the subcontracts with the other 13 universities. The position required the ability to interpret federal policies and procedures regarding reimbursement under title IV-E and IV-B and ensure compliance

with federal and state requirements. A half-time budget coordinator was also needed to develop, monitor, and account for all costs and expenditures of the project statewide.

Each university developed and implemented a recruitment plan to identify students who had expressed interest in child welfare. Each university selected stipend recipients based on standardized selection criteria developed in consultation with the Department. The universities awarded the stipends to selected students in both the bachelor's and master's social work programs.

Each university designated staff (one position for large institutions and part-time positions for the smaller institutions) to provide guidance to the students as they completed their required coursework and supplemental coursework, as necessary, to expand their knowledge specifically in the area of child welfare. These employees coached, mentored, and guided the students throughout their field placements (internships) to demonstrate links between theory and practice. Part of this took place in the recruitment and teaching of the students. Once in the program, the student's needs and progress determined the amount of time needed to coach, mentor, and guide the student through their field placement. In addition, the university employees facilitated the development of the field placement learning contracts and had weekly contact with the students while they were placed in the child welfare agencies.

The Department and the universities worked in partnership to align the social work coursework and field placements with the core competencies taught in the Department's core pre-service training program for newly hired employees. Students exiting the stipend training program had these core competencies and bypassed the five-week pre-service core training required for all new hires (Department, Sheriffs conducting investigations, and CBC organizations).

On a semiannual basis (at a minimum), the Department and UCF met to review the program, the ongoing progress of the students, and the statewide performance measures. Based on the semiannual review necessary adjustments to the program were made.

In addition, the Department monitored the hiring of the graduates to ensure they met federal guidelines for being hired within two months of graduation, their commitment to work, and the recruitment and hiring standards.

This program provided 168 stipends during the Spring 2016 semester. Since then no further stipends have been given out and this program has been suspended due to lack of funds.

The Department staff had planned to develop and negotiate a contract with a third party to conduct an evaluation of the program. The evaluation was to include, but was not limited to, ascertaining whether the program contributed to a more stabilized workforce and determining the performance of the stipend recipients. This has not been completed since the program is currently suspended.

Office of Court Improvement Training Program

The Fostering Connections to Success and Increasing Adoptions Act of 2008 and the Child and Family Services Improvement and Innovation Act (2011) expanded the availability of federal IV-E dollars to training for court personnel. This initiative expands Florida's training plan to include training dependency case managers, family court managers, and magistrates who hear cases involving dependent children.

The Office of Court Improvement plans to hire a "master trainer" to develop and to deliver training to case managers, family court managers, and magistrates hearing cases involving dependent children. In addition, the "master" trainer will assist in staffing the Supreme Court Steering Committee on Families and Children in the Court (FCC). Much of the work completed by the FCC has a training component. Currently, three of the four committee charges have associated training needs, and all four charges have a child welfare tie-in. Finally, there is a high need for court personnel training, in general. The following factors create a significant demand for training:

- The ongoing implementation of Florida Dependency Court Information System (FDCIS).
- The 2016 Child and Family Services Review.
- Cutting edge research in the areas of trauma, brain development, and child development.
- Potential research findings and recommendations from the new Florida Institute for Child Welfare.

The functions of this position include: conducting an annual training needs assessment, developing a training plan to include training related to the work products of the FCC, training court personnel to use the Florida Dependency Court Information System (FDCIS), coordinating training with outside resources, and delivering training.

Florida's Staff Development and Training Plan

SECTION 1: Training Plan Overview
SECTION 2: Headquarters Training Unit Overview
SECTION 3: Description of the Initial Training for New Child Welfare Professionals
SECTION 4: Training Tracking
SECTION 5: Training Funding
Attachment A: Five-Year Staff Development and Training Plan

SECTION 1: TRAINING PLAN OVERVIEW

The 2015 - 2019 Child and Family Services Staff Development and Training Plan (the Training Plan) describes Florida's three staff development and training goals listed below, along with corresponding initiatives. It was developed with careful consideration of the current state (assessment based on the data available) and visioning for where Florida will be in five years, in response to the assessment.[18]

The initiatives were developed during in-person planning sessions with the Department's headquarters training staff, regional training staff, and community-based training partners. These planning sessions were held in March 2014 immediately following the release of the Administration for Children and Families Program Instruction regarding development of the 2015 - 2019 Child and Family Services Plan. Additional input was sought from the Seminole tribe through a telephone conversation with the tribe's family preservation administrator. The Training Plan reflects a combination of both current and new initiatives.

GOAL 1: Professionalize and Strengthen the Training Infrastructure

Initiative 1.1	Annual Needs Assessment, Planning, and Budgeting
Initiative 1.2	Trainer Credentialing
Initiative 1.3	Professionally Developed Curricula
Initiative 1.4	Research and Policy Development
Initiative 1.5	Training Resource Clearinghouse / Support Network
Initiative 1.6	Leadership and Guidance

GOAL 2: Promote a Culture of Career-Long Learning

Initiative 2.1	Career Ladders / Specialty Tracks / Career-Long Curricula
Initiative 2.2	Supervisor Professional Development

GOAL 3: Fully Integrate Training into the Continuous Quality Improvement Process

Initiative 3.1	Continuous Improvement of Training
Initiative 3.2	Strengthen the Link among Training, Data, and Quality Assurance

[18] Note: This plan covers staff training related to Title IV-B and aspects of Title IV-E except training for foster care, adoption, and guardianship. For training of those groups, see Chapter VII, Foster and Adoptive Diligent Recruitment Plan.

SECTION 2: HEADQUARTERS TRAINING UNIT OVERVIEW

Over the next five-year period, the training unit staff will oversee the implementation of the Training Plan. The unit staff members will serve as liaisons between the field and the Administration for Children and Families regional representatives.

Organizationally, the Department's training unit is situated within the Office of Child Welfare. During the last five-year time period, since 2011, the training unit has been disbanded, reorganized, disbanded again, and most recently reorganized in November 2014 with the current staffing configuration. The unit consists of one supervisor and two specialists. The supervisor is dedicated solely to training initiatives. One specialist is dedicated to curriculum design. The other specialist is dedicated training initiatives. In 2016 two additional specialists and an administrative assistant were added to the unit. The specialists are dedicated to training initiatives, funding, and curriculum development.

Programmatically, the training unit will be responsible for ensuring that all training and staff development activities are in direct support of Florida's practice model and Florida's goals for prevention, safety, permanency, and well-being (see Appendix E4. Practice Model). Specifically, the training unit will ensure the following:

- The seven professional child welfare practices are effectively taught and reinforced through curricula, performance expectations, structured field experiences, coaching and supervision.
- Training curricula and field experiences are safety focused, trauma-informed, and family centered.
- Child welfare trainers have ready access to quality training materials and resources and are adequately prepared, supported, and – eventually - certified.

Administratively, the training unit will be responsible for the following:

- Tracking the training activities of the Department and community-based training providers to ensure they are supportive of the Child and Family Services Plan goals and objectives as well as the ongoing professional development of child welfare staff.
- Monitoring the expenditure of Title IV-E training dollars by the Department's regional training offices, sheriff offices, and community-based lead agencies.
- Acting as liaison between the Office of Child Welfare and its Center for the Advancement of Child Welfare Practice (housed at the University of South Florida).

SECTION 3: DESCRIPTION OF THE INITIAL TRAINING AND CERTIFICATION FOR NEW CHILD WELFARE PROFESSIONALS

New curricula: In order to ensure that the newly developed training curriculum supports the Florida Child Welfare Practice Model the proposed implementation date was extended from the summer of 2014 to the summer of 2015 and ongoing. During this time, extensive reviews and revisions were made to the overall framework of the curriculum plan. The newly revised Pre-Service curriculum now consists of Core training and 5 separate specialty curricula. A sixth tack has been designed for Children's Legal Services

that does not utilize Core training, but is supportive of the Florida Child Welfare Practice Model. See below for the content overview of each.

Key design principles: Key principles of the curriculum design: creating a combination of classroom instruction, lab days and structured field days to provide an opportunity for more skills-based or interactive activities along with true reality-based experiences.

Child Welfare Certification: Child Welfare Professionals who specialize in case management including adoptions, foster care licensing, and child protective investigations must earn a child welfare certification through a third-party entity, the Florida Certification Board. After completing the Pre-Service curriculum, the Child Welfare Professional must pass a certification exam and meet additional requirements, including formal education requirements, to achieve provisional certification.

Once provisional certified, the Child Welfare Professional is given a training caseload with a reduced number of cases for the first thirty days. After the first thirty days each agency decides on the professional's caseload size based on their individual knowledge, skills, and abilities.

A provisionally certified Child Welfare Professional must meet the following requirements to earn full certification:

- Complete 1,040 hours of on-the-job experience in his or her certification designation;
- Complete six field observations, as defined by the Third Party Credentialing Entity;
- Obtain twenty hours of individual supervision;
- Obtain ten hours of group supervision; and,
- Obtain an additional ten hours of individual and/or group supervision with an attestation from the supervisor that the Child Welfare Professional has the ability to competently perform child welfare services.

Absent special circumstances, a Child Welfare Professional has one year from provisional certification to attain full certification. To maintain certification, the Child Welfare Professional must complete a minimum of 40 hours of continuing education every two years. The Florida Certification Board tracks compliance with these requirements and maintains a database of all certified professionals and their certification standing.

Core Pre-Service Curriculum

Core is a five-week curriculum consisting of an orientation, 9 classroom based modules, 5 labs, 4 structured field days and ends with a readiness assessment. Core is the first step for hotline counselors, child protective investigators, case managers including independent living case managers, adoptions specialists, and foster care licensing specialists.

Week 1	Week 2	Week 3	Week 4	Week 5
Orientation / Classroom	Lab	Structured Field Day	Lab	Structured Field Day
Classroom	Structured Field Day	Classroom	Lab	Classroom
Classroom	Classroom	Classroom	Structured Field Day	Classroom
Lab	Classroom	Classroom	Classroom	Classroom
Lab	Lab	Classroom	Lab	Classroom

Orientation

In this module, we will welcome participants and provide an overview of training, the purpose of the training, and the contents of the training.

Module 1: Florida's Child Protection System

This module provides an overview of the key legal constructs driving Florida's Child Welfare System, our guiding principles, the major roles and responsibilities of child welfare professionals, and the ethical standards for a child welfare professional.

Unit 1.1: Legal Foundations
The purpose of this unit is to provide new child welfare professionals with an understanding of the core legal constructs that govern Florida's Child Welfare System.

Unit 1.2: Guiding Principles
This unit provides new Child Welfare Professionals with an understanding of the purpose of the child welfare system and the principles that guide our work.

Unit 1.3: Roles and Responsibilities
The purpose of this unit is to begin to inform participants of the various child welfare roles within DCF's Child Welfare System, what they each do, and how they work together, as well as with community partners to achieve child safety, permanency and resilient families.

Unit 1.4: Ethical Requirements of the Child Welfare Professional
The purpose of this unit is to provide participants with a continued discussion on ethical behavior and to highlight the importance of vigilance in behaving ethically.

Unit 1.5: Tools and Resources
The purpose of this unit is to provide participants with the tools and resources they will need to be successful child welfare professionals.

Module 2: The Practice Model
In this module, we turn participant attention to Florida's Child Welfare Practice Model.

Unit 2.1: Florida's Child Welfare Practice Model
This unit introduces participants to the major components of the child welfare system, building on the legal foundations, purpose and principles, and professional roles. Participants will have their first introduction to Florida's Child Welfare Practice Model.

Module 3: Child Development
In this module, participants will learn about child maturation; the child's developmental stages; the child's need for protection, nurturing and well-being.

Unit 3.1: How Children Develop
The purpose of this unit is to provide participants with a strong understanding of the stages of child development and to provide participants with the ability to evaluate children based on the developmental stages. It also introduces the child functioning domain, how to assess a child's functioning, and how to write adequate content about a child's functioning.

Unit 3.2: Child Attachment, Permanency and Well-Being
This unit broadens the focus from the child's developmental stages to look at the child's needs within the family for safety, nurturing and attachment, and well-being, providing definitions and examples, as well as scenario or video practice to determine where these needs are and are not being addressed. In addition, participants learn about the importance of meeting the child's needs from a well-being point of view.

Module 4: Trauma and the Child
This module explains the short and long-term impacts of traumatic events on the child. It also acknowledges the multi-generational nature of trauma and discusses how parents who were traumatized as children continue to experience the effects throughout their adult lives.

Unit 4.1: Trauma and its impact on the Child
This unit portrays for participants the short- and long-term impacts of traumatic events on the child, highlighting the importance of careful, thoughtful professional communication and intervention. The implications of the ***Adverse Childhood Experiences (ACE) Study*** are woven into this discussion, and the activities are designed to produce a visceral impact on participants about the child's experience of trauma. The ability to demonstrate empathetic listening which participants have learned about in Labs 1-4, should be reinforced as the skills needed to communicate with adults who have likely experienced trauma as children and adults.

Unit 4.2: Approaching Children and Families in a Trauma-Informed Manner
Attention in this unit turns to the role of the child welfare professional, highlighting the impact on the child when the approach is not trauma-informed and how one might alternatively behave in a trauma-informed manner. Participants are then provided a list of ways to approach various situations in a trauma-informed manner from the hotline call through case closure.

Unit 4.3: Referring and Advocating for the Child and Family in a Trauma Informed Manner

In this unit, participants learn important facts about screening, assessing and evaluating trauma, as well as the importance of considering culture and historical trauma when approaching children and families in a trauma-informed manner.

Module 5: Family Conditions

In this module, participants will learn about family systems and some of the family dynamics that impact family functioning. Please note that domestic violence and substance abuse are covered in Module 6, Maltreatments.

Unit 5.1: The Basic Social Unit: The Family

In this unit, participants will be introduced to the concept of the family household as a whole rather than a collection of individuals. This unit focuses on our society's most fundamental social entity, which is the family. Today's families might be one parent, two parents or "blended." A child might be raised by extended family members, a foster parent or an adoptive family. A child may be living in a household where one or more families reside together. The family unit, however defined, is responsible for the care, supervision and protection of the child. Children develop their values, beliefs about self and others, and patterns of behavior within their family system. In child welfare, given the many family configurations that exist, our assessment of families focuses on the household where children reside, the people in the household, and how they function.

Unit 5.2: The Impact of Family Dynamics and Culture on Family Functioning

The purpose of this unit is to introduce participants to the concepts of family dynamics and culture to help them approach their child welfare work with the ability to discern healthy and unhealthy family dynamics and cultural issues.

Unit 5.3: Dynamics of Mental Illness

This unit provides participants with a clear understanding of the impact of mental health issues on the families and the role of the Child Welfare Professional in addressing such mental health issues in the family.

Unit 5.4: Dynamics of Poverty

The impact of poverty on the child through family dynamics and other factors can play, the most central role in the child's safety, as well as their short- and long-term prognosis for a healthy, productive life. This unit provides a framework for understanding how poverty impacts the families with whom Child Welfare Professionals work.

Unit 5.5: Dynamics of Limited Cognitive Functioning

This unit defines and describes limited cognitive functioning, as well as discusses the child welfare-related implications of working with a family in which a caregiver has limited cognitive functioning.

Module 6: Understanding Child Maltreatment

To build a solid understanding of maltreatment of children.

Unit 6.1: Maltreatment: Overview

To provide participants with a broad understanding of maltreatment, setting the stage for a deeper look (in the other units of this module) at some specific types of maltreatment.

Unit 6.2: Neglect

This unit provides participants with an understanding of neglect, including the identification and ability to differentiate between types of neglect in the Maltreatment Index, the ability to identify indicators of different types of neglect in family scenarios through descriptions, photographs, behaviors and words and the ability to explain and appreciate the longer-term impact of child neglect maltreatment.

Unit 6.3: Physical Abuse

This unit provides participants with definitions and a detailed examination and understanding of child physical abuse.

Unit 6.4: Sexual Abuse

This unit provides information about the effects of child sexual abuse, including identification of it in the Maltreatment Index, the ability to determine if what is alleged actually rises to the definition of sexual abuse, the ability to identify indicators in family scenarios and through descriptions, and the ability to explain and appreciate the longer-term impact of sexual abuse on the child.

Unit 6.5: Mental Injury

The purpose of this unit is to provide participants with sufficient understanding of mental injury, including the ability to differentiate between types of mental injury; identify indicators of mental injury in family scenarios and through descriptions, behaviors and words; and the ability to explain and appreciate the longer-term impact of mental injury abuse on the child.

Unit 6.6: The Dynamics of Substance Abuse

The purpose of this unit is to educate participants about substance abuse issues and their effect on the family. This unit provides information about the continuum of use, abuse and dependency, and explores signs and symptoms. Learning opportunities are provided that are designed to support child protection professionals in working with families from various cultural groups affected by alcohol and/or drug-related problems. Participants will also be provided opportunities to evaluate these elements through a scenario-based activity, and explain the family dynamics and culture issues they observe. We will also explore substance abuse as a maltreatment.

Unit 6.7: The Dynamics of Domestic Violence

This unit provides an overview of the dynamics of domestic violence, its impact on the children and the survivor of domestic violence, and how to assess when domestic violence may be actively occurring in the family and threatening the child. It also helps participants understand the survivors' actions to protect themselves and their children.

Module 7: Assessment and Analyzing Family Functioning

In this module, participants learn to key points in assessing the six domains of information collection.

Unit 7.1: Information Collection for the Family Functioning Assessment

In this unit participants are introduced to the six domains of information collection.

Unit 7.2: Assessing the Extent of Maltreatment and Circumstances Surrounding Maltreatment

This unit builds participant skill in writing critically-thought, synthesized assessments regarding the extent maltreatment and circumstances surrounding of maltreatment.

Unit 7.3: Assessing Child Functioning

This unit broadens the focus beyond the child's developmental stages, and the need for the child to be safe and experience well-being and permanency to look at the child's functioning needs within his or her family, including assessment and analysis of this domain of information collection.

Unit 7.4: The Parent/Caregiver as a Functioning Adult

This unit will define the domain of adult functioning and help participants understand what information constitutes adult functioning, as well as how to assess and analyze this information. Participants will then review a completed Adult Functioning Domain and identify strengths and gaps in information.

Unit 7.5: Parenting General

The purpose of this unit is to help participants understand the basic concepts associated with the Parenting General domain and understand why this information is important in the overall assessment of Family Functioning. Historically we have focused on a specific maltreatment and when we did ask questions about parenting we centered them on how the parents disciplined. We rarely explored how they came to be parents, what they think about being parents and what type of parent they are. In this domain we will explore all of this using a case example.

Unit 7.6: Parenting Discipline

The purpose of this unit is to help participants understand the Parenting Discipline domain and understand why this information is important in the overall assessment of Family Functioning.

Module 8: Safety and Risk

We have looked a child development, trauma, maltreatments and family conditions in previous modules. In this module, we will explore how these concepts create a safe or unsafe environment for children and we will explore whether a non-maltreating parent has the sufficient protective capacities to protect against the danger.

Unit 8.1: Assessing Present Danger

The purpose for this unit is to focus on what is present danger and identifying the danger threats associated with present danger.

Unit 8.2: Impending Danger, Information Sufficiency and Danger Threats
This unit is the first time that the three core safety components will be introduced, danger threats, child vulnerability and caregiver protective capacities. This will be the first time that all of the six information domains will be pulled together. Participants will begin to see the totality of information about family conditions that is reflected in the six domains. They will begin to learn how sufficient information in the domains is linked to the identification of danger threats.

Unit 8.3: Impending Danger, Information Sufficiency and Caregiver Protective Capacities
This unit will continue to reinforce the inter-relationship of the three core safety components: danger threats, child vulnerability and caregiver protective capacities. Participants will begin to learn how sufficient information in the domains is linked to the identification of caregiver protective capacities.

Unit 8.4: Impending Danger, Information Sufficiency and Child Vulnerability
This unit will continue to reinforce the inter-relationship of the three core safety components: danger threats, child vulnerability and caregiver protective capacities. Participants will begin to learn how sufficient information in the domains is linked to the identification of child vulnerability.

Unit 8.5: Risk, Protection and Prevention
Through Units 1-4, participants have worked to develop an understanding of present danger, then learning and applying the danger threshold criteria to determine if a child is safe or unsafe. In this unit, we turn our attention to another construct – that of the family being 'at risk' of future maltreatment. Participants learn in this unit the basis of the concepts of risk and protection, as well as the concept of prevention, which is another focus of DCF's efforts to keep children safe. The unit ends with an activity designed to help participants see the linkages between the information domains and the protective factors.

Unit 8.6: How Safety and Risk Work to Address Two Different Aspects of Protecting Vulnerable Children
Participants learn in this unit what actuarial risk is. They will learn about the differences between determining actuarial risk and safety and will apply the actuarial risk table to a case study they worked on earlier to determine child safety.

Module 9: Safety Planning
This module covers what must occur once either present danger is identified during the assessment or when the Family Functioning Assessment-Investigation determines that a child is unsafe: safety planning and management.

Unit 9.1: What are Safety Plans?
This unit will focus on what are safety plans, the rationale for creating safety plans, and the responsibility of the agency in creating and managing safety plans.

Unit 9.2: Safety Planning Analysis and Conditions for Return: Purpose
This unit will focus on the safety planning analysis, including the purpose and the development of conditions for return.

Unit 9.3: Creating Sufficient Safety Plans
This unit will focus on safety services and the development of sufficient safety plans.

Module 10: Readiness Assessment
The purpose of the Readiness Assessment is to provide child welfare professionals an opportunity to demonstrate the ability to take concepts learned in the classroom and labs and write logical and succinct domain information to justify conclusions.

Core - Communication Skills Labs

Communication Skills Lab 1: Foundations for Interviewing
This lab follows the presentation of Modules 1 and 2 (*The Child Welfare System* and *Florida's Child Welfare Practice Model*, respectively.) Transfer of learning is achieved when participants move from a conceptual understanding of the values intrinsic to the field of child welfare to actually demonstrating behaviors and basic interviewing techniques consistent with those values during structured learning activities.

Since the best outcomes for children can only be realized when there is a productive working relationship between parent and professional the steps to establish this relationship are covered in depth. This lab introduces the Engagement Continuum describing the full spectrum of interpersonal helping skills. Stages of interviews are discussed to help place the timing and use of more advanced skills (e.g., use of exploring, focusing or directing interviewing skills) in context to the overall information gathering process. In this first lab, participants will demonstrate rapport building through the use of physical attending behaviors.

Unit 1.1: Foundational Concepts
The purpose of this unit is to help new child welfare professionals explore what values and perceptions they bring to their work with families and how these elements can significantly affect what they accomplish with families.

Unit 1.2: How We Gain Trust
The purpose of this unit is to help new child welfare professionals examine the basic elements for building trust—genuineness, respect and empathy. They will observe two different interviews and begin to identify the professional behaviors that made one interview more effective than the other. They will explore what personal values and they will bring to their work with families and how these elements can significantly affect what they accomplish with families if they are not self-aware.

Unit 1.3: Interviewing Engagement Continuum
The purpose of this unit is to introduce new child welfare professionals to the continuum of interviewing skills that they will be learning and how they parallel the phases of an interview. These skills are the manner in which the core conditions of respect and empathy will be demonstrated to the family. There is a heavy emphasis in this unit on the importance of communication skills as a way of truly "listening and hearing" what families are saying and feeling.

Unit 1.4: Attending Behaviors

The purpose of this unit is to introduce new child welfare professionals to the attending behaviors. They will practice the demonstration of empathy through physical attending behavior. They will be introduced to observing and recording feedback.

Communications Skills Lab 2: Exploring Skills

Exploring skills, which include physical and attending behaviors, reflections, silence, reframing, and exception finding questions are used in all interviewing models (narrative, solution-focused, and motivational interviewing). These skills are the bedrock of active listening, and as such, new child welfare professionals should be expected to be reasonably proficient in these skills at the end of core. These skills will be practiced through-out all the labs as new skills are added, and new topics are the focus of an interview.

Unit 2.1: Attending Behaviors

Participants will build on their experience of listening without speaking from Lab 1, and learn the specific types of physical and psychological attending behaviors including the use of silence. They will observe a video and practice the identification of attending behaviors, as well as non-verbal behaviors of the interviewer and family members interviewed.

Unit 2.2: Reflections and Reframing

Participants will build on their understanding of attending behaviors, moving into "active listening" techniques. They will continue to practice the identification and demonstration of attending behaviors while incorporating the use of reflections and reframing.

Unit 2.3: Opening Phase of the Interview

The purpose of this unit is to go back to the phases of an interview and discuss how the exploring skills are used in the opening phase of the interview. Participants will use the information learned to watch a video of two different styles opening an interview. They will be expected to observe interview openings as part of their Child Welfare Professional shadowing and observations during their field days.

Unit 2.4: Wrap-up and Preparing for Field Shadowing

The purpose of this unit is to review exploring skills are used in the opening phase of the interview. Participants will be expected to observe interview openings as part of their Child Welfare Professional shadowing and observations during their field days.

Communication Skills Lab 3: Focusing Skills

Participants will debrief their field shadowing experiences by sharing their direct, personal use or second party observation of exploring skills. Participants will learn what focusing skills are, and how focusing skills in combination with exploring skills are used to steer the interview from an exploration of the general to gathering of specifics. There will be further discussion about the linkages between focusing skills and motivational interviewing, including building ambivalence to facilitate change. This module will begin to differentiate techniques appropriate for children vs. adults, and will provide an intro to child interviewing as the last module. Participants will continue to practice observation, note taking and providing feedback to peers.

Unit 3.1: Debrief Field Observations
The purpose of this unit is to give participants an opportunity to share their field shadowing experiences – particularly their use and observations of exploring skills. This will provide both a review of the exploring skills and an opportunity to further clarify any questions that participants have.

Unit 3.2: Summarization and Questions
This unit moves from exploring skills to focusing skills, which allow the child welfare professional to build on the foundation of general information gathered, zeroing in on the specific details of family conditions and dynamics. The effective use of focusing skills, in combination with exploring skills, will result in gathering necessary descriptive details as well as family perspectives towards the safety of their children and necessity for change. Focusing skills are essential in order for the child welfare professional to have the details needed for safety determinations and to create sufficient safety plans, when needed, that meet the standard of "least intrusive".

Unit 3.3: Interviewing to Enhance Motivation to Change
In this unit, participants are introduced to stages of change and motivational interviewing, both at a high level. All of the skills covered thus far are foundational to motivational interviewing--the ability to build a trusting relationship, conveying empathy, and seeking solutions. The next focusing skills on the engagement skills continuum, positive reinforcement and developing discrepancy require a more direct linkage to the goals of motivational interviewing. Stages of change and motivational interviewing will be covered in greater depth in the specialty tracks.

Unit 3.4: Skill Demonstration
This unit provides opportunities for participants to practice the exploring and focusing skills they have learned thus far. They will also practice observing, giving and receiving feedback. The practice activities are broken into two parts in order to best sequence their skill practice and acquisition. Using case scenarios provided and roles assigned, the first activities will involve the use of listening and focusing skills, but not the more advanced skills of reframing, solution-focused questions, positive feedback and developing discrepancy. The second set of activities will involve the full set of exploring and focusing skills. In this set of activities, participants will use one of their personal topics. The purpose of this second set of activities is to practice the skills, and hopefully, experience the benefit of effective listening and solution developing skills.

Communications Skills Lab 4: Interviewing Children
This lab will be focused on interviews of children, in particular developing knowledge and skills related to linguistic competence. This lab will build on information that has been learned in Module 3, Child Development. As this lab will also follow a field shadowing of interviews of adults, the first unit will be a debrief of those field observations. This lab will focus on linguistic issues generally associated with child age groups, particularly focusing on the pre-school age group. The strategies for interviewing young children are generally transferable to children of all ages, especially in light of the possible developmental delays that many maltreated children experience. These strategies should also be considered when interviewing a person with limited proficiency in the English language. There are several new interviewing techniques introduced in this lab that are best interviewing practices to use with children and adults with limited English proficiency. At the end of this lab, participants should be able differentiate between interviewing skills appropriate for adults vs. children.

Unit 4.1: Debrief Field Observation of Exploring and Focusing Skills
The purpose of this unit is to give participants an opportunity to share their experiences with field shadowing as well as their observations of exploring and focusing skills. This will provide both a review of the exploring and focusing skills and an opportunity to further clarify any questions that participants have.

Unit 4.2: Linguistic Factors with Children
The purpose of this unit is to explain how cognitive development impacts a child's use and understanding of language.

Unit 4.3: Effective Interviewing Skills with Children
The purpose of the unit to learn specific skills that are appropriate for interviews with children who do not have abstract thinking skills.

Unit 4.4: Observation and Demonstration of Child Interviewing Skills
The purpose of this unit is to practice use and observation of child interviewing skills through role plays and field experiences.

Communication Skills Lab 5: Interviewing to Learn about Maltreatment and Surrounding Circumstances
The purpose of this lab is to practice exploring and focusing skills learned for conducting an interview of an adult to learn about maltreatment and surrounding circumstances. Participants will first debrief about their field experiences with observations of child interviews. Participants will practice through various role plays of different case scenarios provided. Participants will also continue to practice skill observation and feedback.

Child Protective Investigators (CPI) Pre-Service Curriculum

The Child Protective Investigators specialty curriculum follows Core and includes three weeks of classroom, labs, courtroom testimony experiences and ends with a readiness assessment. This curriculum was implemented during February of 2015.

Week 1	Week 2	Week 3
Classroom	Lab	Lab – Courtroom Testimony
Classroom	Classroom	Lab
Classroom	Classroom	Lab – Readiness Assessment
Lab	Lab	
Classroom	Classroom	

Module 1: Introduction to Child Protective Investigations Family-Centered

The purpose of this module is to provide the framework for practice and understanding of the Child Welfare Practice Model.

Unit 1.1: Reviewing the Child Welfare Practice Model

The purpose of this unit is to explain the investigative processes and procedures and the roles and functions of Child Protective Investigators (CPI).

Unit 1.2: Overview of the Child Protective Investigation Process

The purpose of this unit is to provide an overview of the investigative process, procedures and essential assessment skills needed to make informed investigative decisions.

Unit 1.3: Family-Centered Practice

The purpose of this unit is to provide investigators with strategies to utilize the family-centered practice approach in the investigative process.

Unit 1.4: Cultural Competence

The purpose of this unit is to familiarize participants with the importance of understanding cultural bias and cultural sensitivity when working with culturally diverse families and environments.

Module 2: Assessment of Hotline (Screen-In) to Assignments

The purpose of this module is to identify and apply the pre-commencement activities and procedures when a hotline intake is assigned for investigation.

Unit 2.1: Pre-Commencement Activities

The purpose of this unit is to identify and apply the pre-commencement activities and procedures when a hotline intake is assigned for investigation.

Unit 2.2: Intakes Not Requiring Investigation

The purpose of this unit is to identify the exceptions to completing pre-commencement activities.

Unit 2.3: Intakes with Special Circumstances

The purpose of this unit is to identify the specific practice and procedural requirements for investigating cases with special circumstances.

Unit 2.4: Special Conditions Referrals

The purpose of this unit is to identify the specific practice and procedural requirements for investigating special condition referrals.

Unit 2.5: Institutional Investigations

The purpose of unit is to identify the practice requirements for Institutional Investigations and explore the different elements making up the Child Institutional Safety Assessment.

Module 3: Commencement of the Investigation: Initial Contact and Present Danger

The purpose of this module is to define the purpose, process and procedures that occur during the commencement phase of an investigation as it relates to present danger.

Unit 3.1: Purpose of Commencement and Planning for Initial Contact

The purpose of this unit is to set the framework for the initial investigation commencement activities.

Unit 3.2: Present Danger

The purpose of this unit is to discuss the requirements for assessing present danger at initial contact.

Unit 3.3: Conducting the Initial Assessment

The purpose of this unit is to provide participants with an understanding of the documentation and notification requirements, as well as an understanding of the importance of observations in the investigative process.

Module 4: Present Danger Assessment

The purpose of this module is to identify the necessary actions that must be completed to assess present danger, establish a present danger safety plan and utilize Children's Legal Services for removal/separation action.

Unit 4.1: Present Danger Assessment

The purpose of this unit is to identify the purpose of and demonstrate the ability to complete a present danger assessment.

Unit 4.2: Developing a Present Danger Safety Plan

The purpose of this unit is to identify the purpose of a present danger plan and the safety actions that are included in the development and implementation of the plan.

Unit 4.3: Temporary Removal Due to Present Danger

The purpose of this unit is to identify the legal basis for a temporary removal due to present danger.

Unit 4.4: Investigations Involving a False Report

The purpose of this unit is to identify the specific practice and procedural requirements for discontinuing an investigation involving a false report.

Unit 4.5: Patently Unfounded Investigations

The purpose of this unit is to identify the specific practice and procedural requirements for discontinuing patently unfounded investigations.

Unit 4.6: Continuing the Assessment Process

The purpose of this unit is to assist CPI's with identifying the gaps in information collections and determining sufficiency to make sound safety determinations.

Module 5: The Family Functioning Assessment – Investigation and Safety Planning
The purpose of this module is to provide participants with the requisite knowledge to effectively utilize the Family Functioning Assessment (FFA)-Investigations to make safety determinations.

Unit 5.1: Overview of the Family Functioning Assessment-Investigation
The purpose of this unit is to introduce participants to the essential components of the Family Functioning Assessment-Investigation and describe its use in practice.

Unit 5.2: Information Collection and Determining Impending Danger
The purpose of this unit is to provide participants an understanding of the family functioning assessment as it relates to determining impending danger.

Unit 5.3: Assessing Impending Danger Related to Caregiver Protective Capacities (CPC) and Child Vulnerability
The purpose of this unit is to provide participants with an understanding of how caregiver protective capacities are utilized in safety determination.

Unit 5.4: In-Home Safety Analysis and Planning
The purpose of this unit is to provide participants with a framework for managing safety, safety planning and analyzing the effectiveness and appropriateness of their plan.

Module 6: Developing in-Home or Out-of-Home Safety Plan
The purpose of this module is for participants to understand how to develop in-home or out of home safety plans, how to analyze their effectiveness, and when to consult with Children's Legal Services (CLS).

Unit 6.1: Managing for Safety
The purpose of this unit is to understand the importance of utilizing appropriate impending danger safety plans to manage for safety in the least intrusive manner.

Unit 6.2: Documentation, Removal and Placement
The purpose of this unit is provide participants with an understanding of the situations that require removal consideration and the documentation that provides the rationale for removal and placement of the child(ren) once the determination is made.

Unit 6.3: Consulting with CLS
The purpose of this unit is to provide participants with an understanding of when to consult with CLS and identify roles and responsibilities between parties.

Module 7: Closing an Investigation – Family Functioning Assessment–Investigation and Case Transfer
The purpose of this module is to review the child maltreatment index, familiarize participants with the utilization of the risk assessment and the investigations case closing process.

Unit 7.1: Maltreatment Evidentiary Standards
The purpose of this unit is to describe the purpose and application of the Child Maltreatment Index.

Unit 7.2: Risk Assessment at Closure
The purpose of this unit is to learn how risk is integrated into the work of the CPI, and for the CPI to learn how to conduct a risk assessment.

Unit 7.3: Investigation Closure – Safe
The purpose of this unit is to familiarize participants with the process, procedures and considerations for closing an investigation when the children are safe.

Unit 7.4: Investigative Closure: Unsafe
The purpose of this unit is to familiarize participants with the process, procedures and considerations for closing an investigation when the children are unsafe.

CPI Practice Application Labs

CPI Practice Application Lab 1: Pre-Commencement Preparation
This lab takes participants through each step of information collection for pre-commencement preparation, using the Sandler case example. Participants will review considerations about the focus of the current FFA, reading prior child welfare history and criminal history, the use of other professional expertise and planning the sequence and location of interviews.

CPI Practice Application Lab 2: Present danger Assessment and Planning
This lab reviews the expectations for tasks to be accomplished during commencement of an investigation by using a case example.

CPI Practice Application Lab 3: Further Information Gathering for Impending Danger Assessment
The purpose of this lab is to review the standards for sufficient information in order to develop the FFA-Investigations, and determine whether or not a child is safe or unsafe. Participants will practice the assessment of information sufficiency, danger threat and protective capacity assessment and impending danger determination by applying the Sandler case example.

CPI Practice Application Lab 4: Impending Danger Safety Planning, Risk Assessment and Closing Interviews with Family
The purpose of this lab is to develop an Impending Danger Safety Plan for the Sandler Case, complete a Risk Assessment and practice a closing interview.

CPI Practice Application Lab 5: Putting It All Together
Unit Overview: This lab provides an opportunity to practice each step of the Investigation portion of the Child Welfare Practice Model using a case example.

Case Management Pre-Service Curriculum

This three-week specialty track follows Core training. All case management staff including Independent Living Case Managers and Adoptions Counselors complete this curriculum. This curriculum was released in July 2016.

Week 1	Week 2	Week 3
Classroom	Classroom	Field Day
Classroom	Classroom	Classroom
Classroom	Classroom	Classroom
Lab	Classroom	Classroom
Field Day	Lab	Classroom

Module 1: Introduction to Case Management

Unit 1.1: Review of Core
The purpose of this unit is to review the concepts and processes learned in CORE training that Case Managers will need in Case Management.

Unit 1.2: Overview of the Case Management Process
The purpose of this unit is to explain the case management process within Florida's Child Welfare Practice Model.

Unit 1.3: Purposeful Contacts
This unit provides an understanding of the skills and personal attributes that contribute to building ongoing interpersonal relationships. Participants will begin to understand the key tasks that they need to accomplish during their contacts with parents, children and caregivers.

Unit 1.4: Laws Rules and Policies
The purpose of this unit is to provide Case Managers with an understanding of the legal foundations governing case management.

Unit 1.4: Understanding Quality Assurance Case Reviews and Family-Centered Practice
The purpose of this unit is to provide participants with an overview of the types of quality assurance reviews that are conducted for case management cases.

Module 2: Case Transfer

Unit 2.1 Case Transfer- What is it?
The purpose of this unit is to review the preparation process for ongoing case management regarding case transfer.

Unit 2.2 Preparing for Case Transfer
In this unit participants will learn about the importance of being prepared for the case transfer process and will walk through the process of receiving a case at case transfer.

Unit 2.3: Case Types
The purpose of this unit is to review the different types of cases that the Case Manager may be involved with.

Unit 2.4: Case Transfer Conference
In this unit participants will review the policies and procedures for conducting a Case Transfer Conference.

Module 3: Safety Management

Unit 3.1: The Case Manager Responsibility for Safety Management
The purpose of this unit is to review the Case Manager's role and responsibility for safety management after case transfer.

Unit 3.2: Managing and Monitoring Safety Plans
This unit provides Case Managers with a complete picture of what safety services are, how they can be used to manage danger, and what safety services are available in their local area.

Unit 3.3: Modifying Safety Plans
This unit provides an overview of the skills needed for safety plan assessment and modification.

Module 4: Court Proceedings and Case Management

Unit 4.1: Taking Court Action
The purpose of this unit is to provide a review of the dependency court process and legal requirements for each of the petitions and hearings that are part of the process.

Unit 4.2: Staffings
The purpose of this unit is to provide a review of the types of staffing that occur during case management.

Module 5: Out-of-Home Care

Unit 5.1: Placement Considerations (Out-of-Home Care)
The purpose of this unit is to provide information on how to make placement decisions for children who are in out-of-home care.

Unit 5.2: Meeting Children's Needs in Out-of-Home Care
The purpose of this unit is to provide participants a review of how the needs for children in Out-of-Home Care are addressed.

Unit 5.3: Family Time and Maintaining Connections
The purpose of this unit is to provide participants a review of what family time is, how to assess family time for progress updates, and the importance of maintaining sibling and other connections.

Unit 5.4: Transitions and Achieving Permanency
The purpose of this unit is to help participants understand the type of transitions children in Out-of-Home Care face and how to help them navigate through the process.

Module 6: Family Engagement Standards - Preparation and Introduction

Unit 6.1: Family Functioning Assessment- Ongoing
The purpose of this unit is to discuss the philosophy and focus of the Family Functioning Assessment-Ongoing.

Unit 6.2: Overview of Preparation
The purpose of this unit is to discuss the initial step in the Family Engagement Standards: Preparation.

Unit 6.3: Overview of Introduction
The purpose of this unit is to discuss the next step in the Family Engagement Standards: Introduction.

Module 7: Family Engagement Standard - Exploration

Unit 7.1: Overview of Exploration
The purpose of this unit is to discuss the third step in the Family Engagement Standard: Exploration.

Unit 7.2: Scaling Caregiver Protective Capacities
The purpose of this unit is to discuss the importance of scaling the Caregiver Protective Capacities to help determine what case plan outcomes will facilitate change.

Unit 7.3: Assessing and Ensuring Child Wellbeing
This unit is an overview of the Child Strength and Needs Assessment including the information needed to complete the assessment and how to scale a child's strengths and needs.

Unit 7.4: Danger Statement, Family Change Strategy, and Motivation for Change
The purpose of this unit is to discuss the importance of establishing a danger statement and family goal with the family to facilitate change.

Unit 7.5: Information Collection Domains
The purpose of this unit is to discuss the importance of gathering sufficient information along the domains to inform the FFA-Ongoing.

Module 8: Family Engagement Standards – Case Plan

Unit 8.1: Building a Case Plan for Change
The purpose of this unit is to teach participants the basic components of case plans and how to integrate knowledge obtained during the FFA-Ongoing process.

Unit 8.2: Addressing Child's Needs in the Case Plan
The purpose of this unit is to teach how to address child's needs in the Case Plan.

Unit 8.3: Concurrent Case Planning
The purpose of this unit is to discuss permanency for children and the need to develop concurrent case plans to ensure timely permanency is achieved.

Module 9: Evaluating Family Progress

Unit 9.1: Ongoing Assessment
The purpose of this unit is to focus on the fundamental purposes of ongoing assessment- sufficiency of safety plans, assessment of family change as to caregiver protective capacities, and child functioning (improved well-being including stability in care). This module provides a high level overview of two fundamental methods for documentation of information about the family, including ongoing assessment information, the child's record in FSFN and the formal Progress Update.

Unit 9.2: Purposeful Contacts
Participants will learn when formal Progress Updates are required, what information must be in the update and for court supervised out-of-home cases, what Judicial Social Study Reviews (Judicial Reviews) must include. Screen shots from FSFN are shown to give participants a view of the Progress Update functionality, and to begin to understand how information completed in other parts of the child's record will pre-fill the pages. This unit is not expected to result in FSFN proficiency; it is simply a glimpse of functionality related to Progress Update and Judicial Review.

Unit 9.3: Progress Update
This session will focus on the fundamental purposes of ongoing assessment- sufficiency of safety plans, assessment of family change as to caregiver protective capacities, and child functioning (improved well-being including stability in care). This module provides a high level overview of two fundamental methods for documentation of information about the family, including ongoing assessment information: the child's record in FSFN and the formal Progress Update.

Unit 9.4: Achieving Safe Case Closures
In this unit participants will learn how to properly close a case.

Lab 1: Courtroom Testimony
This lab prepares CPIs and CMs for the communication skills that are necessary to demonstrate in the courtroom. This lab includes preparation for testimony, responding to questions in appropriate ways, and understanding the strategies that parent's attorneys will use during cross-examination. This unit also discusses the ways in which CPIs and CMs can support CLS as they prepare children for their testimony.

Lab 2: Engage and Motivate
This Lab is an in-depth exploration of the Case Manager's role as a change agent and how they will use engagement skills to achieve the family engagement standards.

Adoptions Pre-Service Curriculum

(Four-week specialty track following core training)

The curriculum for the Adoptions pre-service specialty track is not yet completed. The following information includes a draft outline of planned curriculum. Until the specialty track is completed all Child Welfare Professionals specializing in adoptions will complete the Case Management Specialty track.

Module 1 – Introduction and Adoption Requirements: Definitions, Philosophy, and Values

Unit 1.1: Introduction and Adoption Requirements. The purpose of this unit is to establish the groundwork for the Adoptions training, and to allow participants to learn teamwork principles and get to know each other.

Unit 1.2: Definition, Philosophy, and Values. The purpose of this unit is to provide an overview of the legal and philosophical basis for their role as Adoption Specialists and to clarify their personal values as they relate to adoption. Participants also learn about opportunities to recruit permanent families for children that historically are more difficult to permanently place.

Module 2 – Federal and State Laws and Policies Impacting Adoption

Unit 2.1: Federal and State Laws and Policies Impacting Adoption. The purpose of this unit is to provide participants with the federal and state law and policy that undergirds the adoption processes. This unit also explores the cultural perceptions as well as national and state data regarding adoptions.

Module 3 – Child(ren) & Youth Assessment and Preparation

Unit 3.1: Child(ren) & Youth Assessment and Preparation. The purpose of this unit is to develop participants' skill in the areas of assessing, engaging and preparing children for adoption, giving children the knowledge and skill to be prepared to be adopted, and writing a child study.

Module 4 – Family Assessment and Preparation

Unit 4.1: Family Assessment and Preparation. The purpose of this unit is to develop participants' skill in the area of assessing and engaging and preparing prospective parents for adoption and writing a home study.

Module 5 – Decision Making and Placement Selection in Adoption

Unit 5.1: Decision Making and Placement Selection in Adoption. The socio-emotional process is complex and requires assessment of child/youth and family strengths, challenges, needs, wants and desires and selecting the family with the best potential to meet the child's needs and desires. The purpose of this unit is to review these policies and practices, improve decision-making and engagement skills and introduce participants to the state-specific policies, standardized practices and protocol and effective team planning.

Module 6 – Title IV-E Adoption Assistance Agreements

Unit 6.1: Title IV-E Adoption Assistance Agreements. The Title IV-E Adoption Assistance Agreements unit presents a history of Adoption Assistance in the United States and reviews federal and state laws, policies and eligibility requirements for the Title IV-E Adoption Assistance Programs. Participants discuss negotiating Title IV-E Adoption Assistance Agreements and discuss adoption assistance and medical assistance with older children/youth. Participants build case scenarios.

Module 7 – Post Adoption Services

Unit 7.1: Post Adoption Services. The purpose of this unit is to provide participants with the skills in 1) determining the necessary post-adoption services, 2) developing a post-adoption services plan, 3) stabilize crises and develop a crisis contingency plan, and 4) Develop an individualized plan for family support.

Foster Care Licensing Pre-Service Curriculum

This six-day specialty track follows the Core Pre-Service training. This curriculum is currently being revised, updated and will be released in April 2017.

Module 1: Overview of Licensing Requirements

Unit 1.1: Introduction to Licensing
The purpose Unit 1.1 is to provide an overview of the role of foster care licensing in child protection, the importance of understanding the children we serve, and partnership expectations supported by Florida's Child Welfare Practice Model.

Unit 1.2: Licensing Laws
The purpose of Unit 1.2 is to give an overview of the licensing laws designed to protect children in licensed care.

Unit 1.3: The Role and Skills of Assessment
The purpose of Unit 1.3 is to explain how assessment is an ongoing and mutual process that is fully woven within the fabric of a Licensing Specialist's job.

Module 2: Collaboration and Partnership for Children

Unit 2.1: The Support Team
The purpose of Unit 2.1 is to define the support team in terms of who they are and the services they provide. In addition, the process by which support team members and foster parents support and communicate with one another is highlighted.

Unit 2.2: Co-Parenting and Partnership with Birth Parents
The purpose of Unit 2.2 is to explain to participants how to support foster parents by facilitating their relationships with birth parents.

Unit 2.3: Working with Foster Parents to Manage Children's Behavior and Meet their Needs
The purpose of Unit 2.3 is to discuss the important aspects of parenting children in out-of-home care. In particular, the intent of the unit is to facilitate the participants' understanding and sensitivity to the effects of trauma on a child and on the foster care family when a child who has experienced trauma has transitioned to foster care. The unit also focuses on how provide normalcy for a child. The unit explores the ways licensing specialists and the team can support foster parents in this critically important role including how to prevent disruption and when to offer specialized therapeutic care.

Module 3: Recruiting and Licensing Foster Parents

Unit 3.1: Recruitment, Inquiry, and Pre-licensing
The purpose of Unit 3.1 is to explore the recruitment and inquiry process, including how foster homes are recruited, the steps foster parents must take, and the basic requirements foster parents must meet in order to be recommended for licensure.

Unit 3.2: Initial Licensing
The purpose of Unit 3.2 is to explain to participants the requirements and process for initial licensing of foster homes.

Module 4: Placement, Retention and Re-Licensing

Unit 4.1: Placement, Retention and Re-Licensing Process
The purpose of Unit 4.1 is to explore the placement, retention and re-licensing phase of assessment and licensing including how children are matched to foster homes, how to assess for strengths and needs in order to provide support and training, and the steps foster parents must take and the requirements parents must meet in order to be eligible for re-licensure. Licensing specialists are expected to use professional judgment to ensure that on-going assessments are conducted and supports are provided to prevent placement disruption and encourage foster home retention.

Unit 4.2: Foster Parent Development
The purpose Unit 4.2 is to provide an overview of the process by which Licensing Specialists plan and prepare development opportunities for foster parents.

Module 5: Resolving Foster Parent Concerns

Unit 5.1: Reporting and Responding to Concerns in Foster Homes
The purpose of Unit 5.1 is to review the primary events and elements of reporting and responding to concerns in the foster home including calls to the Florida Abuse Hotline which lead to investigations and foster care referrals.

Unit 5.2: Techniques to Manage Challenges
The purpose of Unit 5.2 is to provide an overview of the events surrounding cases where license revocation is deemed necessary. Specifically, participants will review foster care problem situations requiring resolution and the types of concerns a foster parent might have. In addition, participants will learn how to use Corrective Action Plans and performance improvement plans as a response to problem resolution.

Florida Abuse Hotline Counselors Pre-Service Curriculum

This following curriculum is completed by Child Welfare Professionals who assess reports at the Florida Abuse Hotline.

Module 1: Overview of Process and Protocol

Unit 1: Gives a broad overview of the importance of the Hotline, its purpose and functions, legal basis and terms, and the basics of the job as Hotline Counselor.

Module 2: Obtaining & Documenting Information Regarding the Six Domains for Calls Involving Children

Unit 1: Allows recall of what has been learned about the 6 domains and practice in classifying information that is gathered during the intake process of the Hotline, according to domain, as well as providing hands-on use of the computerized note-taking tool.

Unit 2: Reviews the interviewing skills learned in the Core training and applies those to the interviewing protocol and unique circumstances of the Hotline.

Unit 3: Provides the opportunity to build interviewing skills for obtaining information by critiquing others in recorded scenarios, as well as practicing these skills in a role play simulation.

Unit 4: Gives opportunity for practice in documenting an intake narrative.

Unit 5: Reviews what has been learned about confidentiality and applies directly to the Hotline responsibilities and tasks. Will be presented by Children's Legal Services staff.

Module 3: Information Systems Used by Hotline Counselors

Unit 1: Gives overview and demonstration of the various computer systems that will be used as well as give the first hands-on practice with these systems.

Module 4: Collecting and Assessing Information

Unit 1: Reviews maltreatment knowledge and questions to illicit such information already acquired in Core, as well as review the domains of surrounding circumstances, and child functioning and apply that to screening scenarios.

Unit 2: Reviews the domains of adult functioning, general parenting, and behavior management/discipline, questions to illicit such information, and then apply to screening scenarios.

Unit 3: Reviews the required demographic information to collect, ways to do that while collecting other information and the importance of this information to next steps in the call process.

Unit 4: Builds on what has been learned and apply to establishing jurisdiction when making screening decisions.

Unit 5: Explains what information can be gained by record checks, systems and procedures for doing so, and gives practice in performing record checks.

Unit 6: Delineates when and how to consult with a supervisor.

Module 5: Making the Best Screening/Safety Decision

Unit 1: Builds on the last module and use information gathered to make screening decisions.

Unit 2: Gives practice in documenting screening decisions by entering an intake into the appropriate databases.

Module 6: Closing the Call

Unit 1: Makes the link between the Core concepts of "present danger" or "impending danger" and response priority.

Unit 2: Provides practice in call-closing procedures, including informing the caller of the screening decision.

Unit 3: Provides practice in inputting final information required when closing an intake call.

Unit 4: Applies the procedures for the next steps for closing out an intake, both screened in and screened out and based on response level, as well as for other types of calls/contacts.

Module 7: Vulnerable Adults

Unit 1: Provides opportunity to prepare for taking intakes regarding vulnerable adults who may be the victims of abuse, neglect, or exploitation.

Module 8: Other Contact Types and Situations

Unit 1: Examines contacts that are not made by phone call.

Unit 2: Identifies the differences and procedures for institutional intakes, for children and for vulnerable adults call types.

Unit 3: Identifies what to do with an intake when the computer system is down.

Module 9: Criminal Background Checks

Unit 1: Provides opportunity to identify policies, processes and procedures and apply to performing criminal background checks for Hotline purposes.

Module 10: Putting it All Together

Final performance of applying all course skills to Hotline intake scenarios.

Children's Legal Services (CLS) Pre-Service Curriculum

Within the first six months of hire, all new attorneys must complete the CLS New Hire Orientation training program. The program includes formal classroom training, extensive shadowing opportunities, online training, individual and group assignments/readings and discussions. The program schedule is flexible in that much of the work/assignments are to be completed independently with supervisory guidance and support ensuring there is applicable time form discussions and questions with the Supervisor or Managing Attorney.

New Attorney Guide to Success

1. Philosophy of Children Legal Services:
   - Vision, Mission
   - Children Legal Services Model Memo
   - Dress code
2. Overview of dependency process/Child Welfare Practice Model:
   - Map of Regions and Circuits
   - Map of Community Based Care Lead Agency Map
   - Dependency Flow Charts with hearings and purposes
   - Acronym List
   - Child Welfare Practice Model (separate binder of materials)
   - Parties/participants (community partners, relationships)
   - Benchcards and Guardian Ad Litem Information
3. On-call:
   - 6 Information Collection Standards – Assessment (also see Child Welfare Practice Model Materials in separate binder)
   - Probable cause defined (also refer to Safety Methodology Tab 2)
   - Nexus Generally
   - Safety Plan Workshop PowerPoint
   - Analysis Worksheet
   - Safety Plan Error Indicators
   - Safety Plan Essentials
   - Safety Plan Sample
   - Staffing- Legal Staffing Decision Form
   - Paternity Decision Tree
   - Identification/Engagement of fathers – legal, biological, putative
4. Shelter Hearing/ Chapter 39 Injunctions and Procedure:
   - Shelter Hearing handout

- Sample Shelter Allegations (2)
- Shelter Hearing Checklist
- Child Protective Investigation Sample Predicate Questions
- Injunctions PowerPoint and Sample
- Sample Order Authorizing Access to Child's Medical/Educational Records

5. Pleadings
   - Pleading PowerPoint - Top 10 Practice Pointers
   - Getting the Judge to Say Yes
   - The Essentials of Good Legal Writing Article
   - Dependency petition samples
   - Termination of Parental Rights (TPR) Petition/Expedited TPR Petition
   - Sample Motion
6. Case plan:
   - Case Plan Sample
   - Case Plan Approval Benchcard
   - Attorney Checklist to Review Case Plan
   - A Good Case Plan Must Cheat Sheet
7. Arraignment through Adjudication and Disposition
   - Discovery - Case Files: legal, Child Protective Investigators, Case Management
   - Service
   - Arraignment Hearing at a Glance
   - Arraignment Hearing Checklist
   - Adjudicatory Hearing at a Glance
   - Adjudicatory Hearing Checklist
   - Disposition Hearing at a Glance Benchcard
   - Disposition Hearing Checklist
8. Trial skills in General
   - Know your Judge – From a Judge's perspective
   - Litigation Skills Workshop Notes (National Institute for Trial Advocacy)
   - Case Analysis PowerPoint
   - Dependency Trial Preparation Timetable
   - 25 Tips for Trial Preparation (from parents' attorneys)
   - Theme, Theory and Why Organization is Important
   - Trial Advocacy Discussion Guide
   - Judicial Notice Best Practices and Sample

9. Opening Statements
   - Making a Compelling and Persuasive Opening Statement
   - Opening/Closing Chart
   - National Institute for Trial Advocacy PowerPoint Presentation
   - Opening Statements

- Opening Sample Notes

10. Direct Examination of the lay witness
    - Direct Examination for Child Welfare Attorney
    - Direct Examination Cheat sheet
    - National Institute for Trial Advocacy When Your Witness gives you the wrong answer PowerPoint
    - Direct Examination
    - Guides to give your witnesses to help: Guidelines for Effective Testimony etc.
11. Cross Examination
    - 10 Commandments of Cross Examination handout
    - National Institute for Trial Advocacy Cross Examination PowerPoint
    - National Institute for Trial Advocacy Impeachment PowerPoint
    - Cross Exam – How to Write, Deliver, Impeachment
    - Tips for Cross Examining a Defendant or Defense witness
    - Tactics and Responses handouts
12. Expert Witnesses
    - Expert Cheat Sheet and Sample Cross Exam
    - Sample Predicate Questions for Direct
    - Do not need to tender witness as an expert
    - Article on Cross Examination of Psychologists
13. Evidence
    - Rules of Evidence Most Relevant to Dependency Cases
    - National Institute for Trial Advocacy Foundations PowerPoint
    - Business Records Certification
    - Sample Questions – Audio and Visual
    - Evidentiary Objections
    - Hearsay Exceptions
    - Fla. Evidence Code Summary Trial Guide
14. Closing arguments
    - National Institute for Trial Advocacy Closing Argument PowerPoint
    - Closing/Opening Chart
    - Sample Closing Argument with Notes
15. It is all about the children:
    - Training– When Basic Needs Are Not Met
    - Protecting Children from Toxic Stress
    - Handbook on Questioning Children
    - Preparing Dependent Children for Court
    - Children in Court – Rule 8.255 and Best Practices
    - Child Testimony: In Camera/Hearsay
    - Child Victim Hearsay PowerPoint
    - Child Victim Hearsay Sample Questions

- Notice of Intent to Offer Child Hearsay Statements and Motion to Admit
- She Said What? What to do in Civil Domestic Violence Proceedings with Child Hearsay (helpful tips on child hearsay)
- Sexual Assault Nurse Examiner (SANE) Testimony in Child Sex Abuse Cases Article
- Transitioning Children Benchcard
- Education – Appointment of Surrogate

16. Judicial Review:
    - Benchcard Judicial Review at a glance
    - Judicial Review (JR) Checklist
    - JR PowerPoint
    - Special Considerations for Youth Transitioning to Adults
    - Master Trusts
    - Sample Questions for Judicial Review
17. Permanency Review – 12 months or sooner:
    - Permanency Hearing at a Glance Benchcard
    - Enhancing Permanency for Youth in Out-of-Home Care
    - Permanency Cheat Sheet
    - Permanency Goals
18. Termination of Parental Rights – Can you? Should you?
    - Termination of Parental Rights Adjudicatory Hearing at a Glance
    - Termination of Parental Rights Advisory Hearing at a Glance
    - Advisory Hearing Checklist
    - Best Interest Testimony Best Practices (Sample Questions)
    - Termination of Parental Rights Petition Samples
    - Trial Brief Samples
    - Request for Judicial Notice (see Trial Skills in General)
19. APPEALS
    - Recurring Practice Problems
    - What's the Deal with my Appeal PowerPoint?
    - Appeals in general
20. Interstate Compact on the Placement of Children (ICPC)
    - Interstate Compact on the Placement of Children (ICPC)PowerPoint
    - Five Federal Laws and the National Compact
    - Motions for Order of Compliance (various regulations)
    - Statements of Case manager (various regulations)
    - Orders of Compliance
21. Indian Child Welfare Act (ICWA)
    - Indian Child Welfare Act
    - Technical Assistance Brief – Indian Child Welfare Act
    - Sample Notice to Tribe

22. Psychotropic Mediations/Residential Placement
    - Benchcard Psychotropic Medication
    - Benchcard Statewide Inpatient Psychiatric Placement Program (SIPP)
    - Sample Questions for Statewide Inpatient Psychiatric Program hearing
    - Sample Motion and Order
23. Independent Living/Extended Foster Care
    - Chapter 65c Extension of Foster Care
    - Frequently Asked Questions on Extension of Foster Care
    - Medicaid Eligibility for kids until 26
    - Independent Living Services and Checklists
24. Florida Safe Families Network (FSFN)
    - Children Legal Services/Florida Safe Families Network How to Guide
    - Retrieving an Overview of Your Caseload from Florida Safe Families Network
25. Miscellaneous topics
    - Intervention for private adoption PowerPoint and materials
    - Human trafficking
    - Ludwig Handout

Day One: Policies and Procedures for DCF

Task: Receipt of equipment, books, materials and manuals - complete online Department of Children and Families trainings for new employees.

Day Two: Policies and Procedures for CLS

Tasks: *Review New Attorney Guide to Success Chapter 1-2*

Review Organizational chart of Children Legal Services,
Review Children Legal Services Performance Measures/Metrics with Supervisor.
Acknowledge Performance Measures Expectations via People's First.

Introduction to various data Base Systems Training: Westlaw, Florida Safe Families Network, Electronic Document Management System (EDMS), Comprehensive Case Information System (CCIS), incident reporting system, Children Legal Services Webpage, Department of Children and Families Web page, People's First Time Card, local Clerk of Court access, e-Filing access registration) with Administrative Assistant/Paralegal Specialist (as designated by the office for technical assistance).

Begin review of Chapter 39 Book
Begin review of New Attorney Guide to Success Binder
Begin review of Trial Advocacy for the Child Welfare Attorney

Days Three and Four: continue review books

Continue review of Chapter 39 Book, New Attorney Guide to Success Binder: Trial Advocacy for the Child Welfare Attorney.

Review New Attorney Guide to Success Chapter 15 – It is all about the Children

Days Five and Six: Staffing and LSD Forms

Tasks: *Review New Attorney Guide to Success, Chapter 3/LSD Form Information and Chapter 4*

Staffing Forms and Determining Legal Action with Supervising Attorney/Managing Attorney
Sample File with Paralegal Specialist.
Injunctions
Observe staffing, if available, with Senior Attorney/Supervising Attorney

Review Safety Methodology Materials

Continue review of Chapter 39 Book, New Attorney Guide to Success Binder: Trial Advocacy for the Child Welfare Attorney. ***(continue daily until completed)*

Review Statutes: 61, 63, 119, 409, and other statutes related to ancillary issues ***(continue daily until completed)*

Day Seven: Child Welfare Practice Model Training

This is just the beginning of the training on the new practice model. Once the webinar has been viewed in conjunction with all the handouts, the Supervisor/Managing Attorney (MA) must continue to work "on the line" with the attorney as cases are staffed and files reviewed. The best way to become competent is work on the cases and consult with supervisor, then review materials again.

Day Eight: Shelters, begin shadowing experienced attorney, draft pleadings

Tasks: *Review New Attorney Guide to Success, Chapter 4 Shelter Hearing and Procedure*

Shelters- Staffing, Drafting Petition, Hearing with Supervising Attorney/Managing Attorney
Review Shelter rules and statutes
Discussion/Debrief regarding Shelter Hearing, rules and statutes with Supervising Attorney/Managing Attorney
Watch Webinar – Who's Your Daddy

Days Nine and Ten: Begin the analysis of whether a child is dependent.

Tasks: *Review Webinar/materials on* Children Legal Services *Website – Pleadings*

Review New Attorney Guide to Success Binder Chapter 5, Pleadings
Drafting dependency petition with Supervising Attorney/Managing Attorney
Review Guide to Success Binder Chapter 6-7, Arraignment through Disposition
Shadowing Settlement Conferences/Case Plan conferences
Watch Webinar - Without Harm, Your Allegations Have No Charm
Watch Webinar - How to Prevail at Shelter on Impending Danger Cases

Days Eleven – Fifteen: Preparing case for trial

Tasks: *Review New Attorney Guide to Success Ch. 8-14 (Litigation Skills)*

Finish National *Institute for Trial Advocacy Book, Trial Advocacy for the Child Welfare Lawyer*
Review Webinar on Children Legal Services *Website – Hello Daubert, Goodbye Frye (experts)*
Facilitate settlement conferences/case plan conferences
Redact Discovery/Provide Response to Discovery

Trial Preparation
Prepare Witnesses
Review Appeals process/procedure

Day Sixteen – Twenty: Judicial Review Process

Tasks: *Review New Attorney Guide to Success Chapter 16-17 Judicial Review/Permanency Review*
Review New Attorney Guide to Success Chapter 22 Psychotropic Medications
Review Webinars on Children Legal Services *Website – 2014 Changes to Independent Living/Extended Foster Care*
The Master Trust/Surrogate Parents
Read Judicial Reviews
Attend Judicial Review
Attend Dispositions
Review Case Plans

Day Twenty-One – Twenty-Five: TPR Process

Tasks: *Review* Children Legal Services *Webinar, Termination of Parental Rights Best Practices*
Review New Attorney Guide to Success Chapter 18
Attend permanency staffing
Drafting a Termination of Parental Rights Petition for Supervising Attorney/Managing Attorney review and comments
Become familiar with:
- Grounds for Termination of Parental Rights
- Least Restrictive Means Test
- Manifest Best Interest

End of First Month: Attend 3 Day New Children Legal Services Attorney Training

The Children's Legal Services training team conducts an in person newly hired Children Legal Services attorney training four times per year, rotating the location around the state. The Director welcomes each class. The training is done by the Training Director, Deputy Director, Statewide Trainer, Appellate Director and occasionally a Managing Attorney assists.

The curriculum is as follows:

- Introductions and your "why"
- Philosophy of CLS/DCF
- Dependency Overview/Dependency Process
- The Decision regarding shelter
- The Legal Staffing Decision Form
- Legal Writing – pleadings – Getting the Judge to Say "Yes"
- Drill on Cross Examination for each attendee to practice a cross examination question
- Dependency through Adjudication
- Overview of the Sample Case Sample facts and evidence - the case sample includes shelter allegations, a dependency Petition, CPI chronological notes, 2 Expert Reports, photos, Letters – which is a launching point for the training
- Case Plans and Judicial Reviews
- Trial Skills Overview

Direct Examination of a fact and expert witness

- Direct Examination Workshop – a practice breakout utilizing the National Institute for Trial Advocacy methods (each attendee practices using the case sample and the trainers provide feedback and suggestions for improvement)

Cross Examination

- Cross Examination Workshop - a practice breakout where each attendee practices a cross examination using the case sample and the trainers provide feedback and suggestions for improvement

Evidence

- Evidence workshop – a practice breakout similar to above

Termination of Parental Rights
Opening statement/closing argument
Closing argument workshop – same as other practice breakouts
It's all about the children and transitions
Vicarious Trauma

Month Two – Chair/Co-chair Trial

First or Second Chair Trial.
Continue shadowing as needed and reviewing materials.
Continue review of New Attorney Guide to Success
Watch Webinar on Children Legal Services *website: Evidence 2014*
Watch Webinar – Top 20 Tools for your Dependency Law Tool book

Month Two - Three

Complete review of New Attorney Guide to Success
Review Webinars on CLS Website –
Interstate Compact on the Placement of Children (ICPC) *101*
Science of Attachment (Zeanah)
Youthshine Panel – We shall be heard
Ethics in Child Welfare
Risk Factors Associated with Maltreatments by Dr. Lambert, Child Protection Team
Listen in on Decision Team Staffing (Title varies by Circuit) in your Circuit

Ongoing Training

Mandatory Webinars
Paternity Webinar
Without Harm, Your Allegations have No Charm: Drafting pleadings and proving harm
ICWA and ICPC
Recent Developments in Case and Statutory Law
What Now, Taking Impending Danger Cases to Court

Appellate Case Law Conference Calls
The appellate teams provide recent cases and discussions regarding the rulings for all of CLS.
Occurs approximately every two months.

Supervisor in-person two-day training for all of the CLS Supervisors with training provided by the training team, an MA, and outside speakers. The training includes the following topics:

Introduction and your why
Why Here, Why Now
FSFN as a management tool
Impending Danger
Conflict Resolution
Safety methodology and conditions for return
Leading, Who Am I
To Stress or Not to Stress – stress management
CLS Policies including performance metrics and HR
How Do I Get Help – resources for supervisors
Leadership with No Excuses – How Do I Treat Attorneys and Staff
On Boarding newly hired CLS attorneys
Why Am I Doing This?

Advanced Litigation Academy two-day training with training provided by the training team, an MA, and outside speakers. The Agenda included the following:

Trial Preparation
Advanced Direct Examination
Direct Examination Workshop - a practice breakout utilizing the National Institute for Trial Advocacy methods (each attendee practices using the case sample and the trainers provide feedback and suggestions for improvement)
Advanced Cross Examination
Cross Examination Workshop – same as above
Efficiency – Finding an Extra Hour in Every Day and from Distracted to Productive
Advanced Evidence
Evidence Workshop
Objections

SECTION 4: TRAINING TRACKING

Training events and courses are tracked two ways: 1) quarterly training reports from the community-based care providers, Sheriff Offices, Department of Children and Families regions, and CLS; and 2) the training tracking module in the SACWIS system.

Pre-Service training

Quarterly training reports. Aside from standard, statewide pre-service curricula for newly hired child welfare professionals, training conducted across the state varies among the regions, the community-based care providers, and the sheriffs' offices based on their individualized needs. Four times a year, the regions, the community-based care providers, and the sheriffs' offices submit a summary of all training courses they have conducted.

See Appendix E6: *Overview of Training*

Detailed spreadsheets of individual training available on request:

- *Quarterly Reports October 2015 to December 2015*
- *Quarterly Reports January 2016 to March 2016*
- *Quarterly Reports April 2016 to June 2016*
- *Quarterly Reports July 2016 to September 2016*

Training tracking in SACWIS. In early 2013, a new training tracking feature was implemented in Florida's SACWIS system. Per directive from the Department's central office, all child welfare professionals across the state are encouraged to use the system. Each professional is directed to self-report the training he or she has received.

SECTION 5: TRAINING FUNDING

The Department allocates funding specifically for training among community-based care lead agencies, sheriff's offices conducting protective investigations, and Department regions providing direct services. Funds are for the purposes of providing child welfare services staff with the mandated pre-service, and advanced in-service training that reflects the agency's system of care and meets both agency and individual training needs. Additionally, the Department uses training funds from other grants, such as the Children's Justice Act, in order to meet the specific training needs that support the goals and objectives of the grant program. CBC lead agencies are restricted to using these funds for child welfare education and training services only. To ensure appropriate expenditure of these funds, each agency receiving training funds submit quarterly training reports.

Two major factors affected the budget/cost of training beginning in SFY 2015/16. First, legislative appropriations to support major new Department initiatives in child protection and welfare have provided additional training funding. Second, the Children's Bureau and the state amending the Terms and Conditions for the Title IV-E Demonstration Waiver removed training from the "cap" for administrative claims, and therefore federal FFP may now be claimed for allowable training activities including In-service, Pre-Service, and field training performed by the Department, sheriff offices, and CBC's.

Beginning in October 2016 Title IV-E federal FFP will not be actively claimed for training conducted by Sherriff Offices or Department of Children and Families regions to Child Welfare Professionals specializing in child protective investigations.

Training Plan Appendices:

- Appendix E1 Florida's Training Plan Matrix
- Appendix E2 CBC Training Expenditures
- Appendix E3 CPI Training Allocation
- Appendix E4 Practice Model
- Appendix E5 Overview of Training

- Appendix E6 2015-2016 Training List

Note: Training Information details available on request:

2015 Quarterly Reports July to September for community-based care agencies, Sheriff Offices, and Department of Children and Families regions.

2015 Quarterly Reports October to December for community-based care agencies, Sheriff Offices, and Department of Children and Families regions.

2015 Quarterly Reports July to September for community-based care agencies, Sheriff Offices, and Department of Children and Families regions.

2015 Quarterly Reports October to December for community-based care agencies, Sheriff Offices, and Department of Children and Families regions.

Appendix E1.

Florida's Training Plan Matrix

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Appendix E1: FLORIDA'S FIVE YEAR STAFF DEVELOPMENT AND TRAINING PLAN FOR 2015-2019

FLORIDA'S CHILD WELFARE TRAINING SYSTEM FIVE YEARS FROM NOW

OUR VISION

…. is to create a formal statewide training system that supports the three goals of the Child and Family Services Plan as well as the purposeful and continual development and career progression of the Department's child welfare professionals – both employed and contractual – throughout the lifetime of their employment.

GOAL 1: PROFESSIONALIZE AND STRENGTHEN THE TRAINING INFRASTRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
Initiative 1.1: Annual Needs Assessment, Planning and Budget The Department allocates almost all (see note below) child welfare training dollars to the regions, community-based care agencies, and sheriffs' offices to train investigators, case managers, licensing specialists, adoptions specialists, and supervisors. In turn, those entities spend their training budgets as they deem appropriate. Spending on training is on par with national averages. However, it is unknown whether the training budgets adequately meet the training needs. Note: Approximately $1,000,000 is spent on training from the headquarters office, half of which is from the Children's Justice Grant funds to pay for approximately 700 scholarships for attendance to the annual statewide child welfare conference. Supporting information and data: • According to the *2013 State of the Industry Report* issued by the American Society for Training and Development, as a percent of payroll, direct	A fully funded training system based on the state's child welfare training needs. Training dollars are spent in a purposeful way, leveraging the amount available to achieve the greatest impacts in the areas of greatest need.	• With input from staff around the state, develop a method for conducting statewide and local assessments (an annual performance needs assessment and an annual data-driven training needs assessment) to identify gaps in child welfare staff skills and knowledge that will inform in-service training, modify pre-service training, and identify emerging needs. ***Year one.*** *Needs assessments completed* • Clearly define training activities to be able to accurately capture training expenditures at headquarters, regional offices, community-based care providers, and sheriffs' offices. ***Year one****. Community-Based Care agencies have submitted detailed semi-annual training reports in year one, goal is to have regions and Sheriff's offices also submit these reports in year two.* ***Year two:*** *See below.*

GOAL 1: PROFESSIONALIZE AND STRENGTHEN THE TRAINING INFRASTRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
expenditure on learning was 3.6% in 2012, with an average of $1,195 spent per employee. • On average, over the past three years, the community-based care agencies spent 1.8% of their payroll budget on training (2.08% in 2011, 2.02 percent in 2012, and 1.19 percent in 2013). • On average, over the past three years, the Department's regions have been allocated training budgets that are 3% of the total salary costs. This allocation represents an average spending of $1,551.31 per position. • On average, over the past three years, the sheriffs' offices spend 2% of their total budgets on training. (Spending costs per employee or as a percentage of payroll costs are not available.) See Appendix A1, CBC Training Expenditures and Appendix A2, Training Allocation CPIs		***Year three*:** In year two a quarterly report was developed to track trainings and expenses. This report has continued to be used in year three. • Develop statewide and local 2-year training plans and training budgets; adjust annually as needed. *Year two and ongoing.* *Year two. Community-Based Care agencies have submitted detailed semi-annual training reports from December – June 2015. Beginning in July 2015 Community-Based Care agencies, Department of Children and Families regions, and Sheriff's offices submitted Quarterly training reports. Goal is to continue to work towards developing statewide and local training plans that guide training budgets and the provision of training.* ***Year three.** The development of a two-year training plan and training budget has been delayed as the issues with the usage of Title IV-E training funds and training tracking are improved. The work done on solving these issues will help guide the development of statewide and local training in year four and five.*

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GOAL 1: PROFESSIONALIZE AND STRENGTHEN THE TRAINING INFRASTRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
Initiative 1.2: Trainer Credentialing Statewide, there are approximately 150 trainers with widely varying degrees of training experience and expertise. Some trainers hold credentials from the former credentialing program. However, Florida does not currently have a credentialing program for child welfare trainers. With attrition, the number of trainers who do not meet any standards will grow. Supporting information and data: • Seventeen percent of child welfare trainers do not hold a formal trainer certification (total number of respondents is 138). • Ongoing professional development for trainers is highly variable around the state. While 39% of the 138 respondents have taken over 6 trainer-related courses in the past three years, 24% report having taken no professional development trainer-related courses over the past three years. • In a 2007 review of child welfare training literature conducted by the Boston University School of Social Work, research indicated that adult learners generally reported higher levels of satisfaction and experienced higher levels of achievement under instructors who are competent educators and use advanced practice skills. • Organizations must be sure that the people who deliver training have the competencies of effective adult educators (Williams, 2001). See Appendix B, Trainer Survey Findings	Florida has a statewide network of qualified trainers to deliver pre-service, in-service, specialty track, and emergent needs training for all Child Welfare Professionals (hotline counselors, child protective investigators, case managers including independent living case managers, adoptions specialists, foster care licensing specialists, department attorneys, and supervisors). Ongoing professional development of trainers is required through a continuing professional development process. All trainers meet specified standards and competencies. Trainers use advanced teaching techniques, student engagement, and classroom management techniques, such as: • Place value on the experiences learners bring with them and relate the training to learner experience. • Adjust delivery style to the overall learning needs, skill level, and organizational context of the training group. • Create a supportive environment / encourage discussion /provide objective feedback. • Facilitate problem solving / stimulate critical reflection.	1. Create a statewide workgroup that will use the former certification standards as the basis for the development of a new program. These standards will address initial certification as well as ongoing requirements for recertification. ***Year one.*** *A statewide workgroup was created to address formal standard qualifications for a child welfare trainer program. Completed.* 2. Secure, through the legislative budgeting processing, headquarters office capacity to administer and appropriately support a statewide network of certified trainers. ***Year two****. Title IV-E training funds have been allocated to this purpose and exploration has begun on contracting out the trainer credentialing program. Headquarters will provide oversight for this program.* ***Year three****. The contracting process is being completed for this program. Headquarters will provide oversight.* Embed the certification program in administrative code. ***Year two.*** *This goal is being moved to year three.* ***Year three****. Statute changes must be made to allow the Department to make changes to administrative code regarding trainer credentialing. Legislation has been drafted and is currently being considered by the legislature.* 3. Administer the program.

GOAL 1: PROFESSIONALIZE AND STRENGTHEN THE TRAINING INFRASTRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
	• Provide clear presentations and well organized lectures.	***Year two and ongoing***. *This goal is being moved to year three and ongoing* ***Year three***. *Since the contracting process is still being completed this goal is moving to year four and ongoing.*
Initiative 1.3: Professionally Developed Curricula The new pre-service curricula was developed using professional instructional designers. In-service training for Child Welfare Professionals may come from any source. The state does not have standards for curriculum development. Supporting information and data: In a survey that allowed trainers (138 respondents) to select all responses that applied: • Seventy-six percent indicated that the trainers themselves develop curricula (staff who do not hold degrees in instructional design). • Fifty-six percent responded that training is developed in-house by professional curriculum developers. • Forty-four percent reported that some training development is through contractual arrangement. • Thirty-nine percent reported they use training that is "off-the-shelf" and available for public use. There have been significant advances in the field of child welfare training over the last 25 years, one of which, most notably, is the use of "a calculated	The headquarters training unit has a full-time instructional designer and training specialists. They construct learning experiences that: 1) structure content in a way that best reflects the way the brain processes new information – from simplest terms and definitions to rules and procedures to critical thinking (analysis & problem-solving); and 2) effectively use instructional techniques, such as demonstration, practice, feedback, and structured transfer activities, to reinforce the application of that new information. These instructional designers maintain the pre-service curriculum and develop in-service curriculum for statewide use, as identified through the formal needs assessments and in support of the CFSP goals. The instructional designers provide technical assistance to staff, who develop courses based on local training needs. The curricula is posted to the web-based Training Resource Clearinghouse (see 1.5 below) and available to all credentialed trainers.	1. Request budget allocation for three full-time degreed curriculum developers to be housed at the headquarters office. ***Year one.*** *Budget allocation was requested but funding will not be available until year two. Completed.* 2. Recruit and hire for the new positions. ***Year one.*** *Funding not available until year two.* ***Year two***. *One full-time degreed curriculum developer and one specialist are devoted to curriculum development. Completed.* *Year three. One full-time degreed curriculum developer and one specialist remain on staff and are devoted to curriculum development with a goal of hiring additional staff that specialize in curriculum design.* 3. Develop standards for curriculum development. ***Year one***. *Legislative Budget Request submitted and approved for additional staff to develop curriculum standards.* ***Year two***. *Standards are in the process of being developed.*

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GOAL 1: PROFESSIONALIZE AND STRENGTHEN THE TRAINING INFRASTRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
approach to training development focusing on competencies" (Brittain, 2004). Such a formal, "calculated" approach implies a certain skillset which is why the National Staff Development and Training Association (of the American Public Human Services Association) has identified "curriculum designer" as one of the nine positions needed to adequately staff a public welfare training program. Formally trained curriculum designers have the skillset needed to develop learning experiences for adults that match learner needs with appropriate content and instructional methods (Literature review, Boston University School of Social Work, 2007).	Training developers in the regions, community-based care agencies, and sheriffs' departments use basic statewide standards when designing curriculum. Curriculum is routinely shared with the Seminole Tribe of Florida.	***Year three.*** *Standards are still in the process of being established for the curriculum produced at headquarters.* 4. Develop curricula as identified by the formal statewide needs assessments and in support of the CFSP goals. ***Year two.*** *Curriculum development has focused on Pre-Service training. The Child Protective Investigations Pre-Service curriculum was implemented and the Case Management Pre-Service curriculum was developed.* ***Year three.*** *Curriculum development has continued to focus on the Pre-Service training. The Case Management Pre-Service curriculum was finalized, the Foster Care Licensing Pre-Service curriculum is in development, and the Core Pre-Service curriculum is being updated. In-Service curriculum development has been limited due to time constraints and has been focused on supporting statewide policy and practice enhancements.* 5. Post curricula to the Training Resource Clearinghouse for the network of 150 trainers to use. ***Year two.*** *After development all curriculum is posted to Florida's Center for Child Welfare for the network of trainers to use.* ***Year three.*** *After development, curriculum continues to be posted to Florida's Center for Child Welfare for the network of trainers to use. Ongoing.*
Initiative 1.4: Research and Policy Development	The Continuous Quality Improvement office within the Office of Child Welfare has two full-time staff who conduct formal research and	1. Create a research workgroup. Engage universities. ***Year one.*** *Florida State University's Florida Institute for Child Welfare was established. The institute is*

GOAL 1: PROFESSIONALIZE AND STRENGTHEN THE TRAINING INFRASTRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
There is no formal, ongoing review of current literature or formal affiliations with child welfare research groups to stay abreast of the latest evidence-based practice recommendations. Likewise, there is no systematic examination or validation of internal practices in comparison to current literature. Training is not informed by these cutting-edge evidence-based findings.	review current literature. These staff members have affiliations with child welfare research groups to stay abreast of latest evidence-based practice recommendations. In turn, the research findings yielded from these activities are used to inform policy and practice; design training informed by research; promote supportive and strategic legislative agendas and requests; and prepare position papers to drive media responses and public relations efforts.	*mandated by legislation to conduct research on policy and practice standards that prioritize safety, permanency, and well-being outcomes. Completed.* 2. Create a research agenda based on continuous quality improvement findings and input from stakeholders and program professionals. Ensure that the agenda links to the CFSP goals and the practice model. ***Year three**. Florida State University's Institute for Child Welfare continues to be mandated by law to conduct research on policy and practice standards. The Department is working with the Institute to use the research they have conducted. Currently research on training is not being conducted by the Department.* 3. Draft research briefing papers and circulate for workgroup review and internal review. *Year three and ongoing.* ***Year three,** see above.* 4. Publish research briefings. *Year three and ongoing.* ***Year three**, see above.* 5. Monitor action taken in response to the recommendations, specific to training. *Year three and ongoing.* ***Year three**, see above.*

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GOAL 1: PROFESSIONALIZE AND STRENGTHEN THE TRAINING INFRASTRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
Initiative 1.5: Training Resource Clearinghouse / Peer Network Sharing of trainer resources and networking among the trainers varies throughout the state. Department-affiliated trainers in the regions, community-based care agencies, and sheriffs' offices are loosely associated by a statewide peer network for periodic, one-way communication and delivery of information. Trainers at a local level may or may not network and share. Supporting information and data: • In a recent survey, 51% of the 138 trainers who responded expressed high levels of satisfaction with the availability of shared trainer resources (best practices, national literature, curriculum, etc.) while 34% expressed low levels of satisfaction. • Fifty-one percent of the 138 respondents expressed high levels of satisfaction with the opportunities for peer interaction and learning opportunities among child welfare trainers, while 38% expressed low levels of satisfaction.	Across the state, certified trainers view themselves as members of a network of professional child welfare trainers. As credentialed members of this network, they have exclusive access to the Training Resource Clearinghouse that provides a continually expanding library of high-quality, professionally developed training and resource materials. Furthermore, trainers are associated through a network that provides regular two-way communication through various forums (on-line chats, Facebook, and flash surveys for quick field input). Finally, trainers meet face-to-face at least semi-annually for their own professional development, to address issues, and to plan for the future. The Seminole Tribe of Florida is a member of the network, participates in the semi-annual meetings, and uses (and contributes to) the Training Resource Clearinghouse.	1. Using a national review that has already been conducted, work with the University of South Florida to identify curricula to post on the Center for Child Welfare website. Routinely post curricula as it becomes available and alert the trainer network when it is posted. ***Year one.*** *The Office of Child Welfare continuously reviews curriculum and resources that will be posted on the Center for Child Welfare's website.* ***Year two.*** *The Office of Child Welfare continues to review curriculum and resources that will be posted on the Center for Child Welfare's website.* ***Year three.*** *The Office of Child Welfare continues to review curriculum and resources that will be posted on the Center for Child Welfare's website.* 2. Determine ways to formalize the peer network into a web-based, active provider of technical assistance information and real-time sharing of information. Add the Seminole Tribe of Florida to the network. ***Year one.*** *The peer network has been developed; however a web-based technical assistance venue has not been created. A formalized process has been created for the Office of Child Welfare to receive questions from the field and responses are posed on a FAQ link on the Center for Child Welfare's website.* ***Year two.*** *The peer network remains in place as does the formalized process for the Office of Child Welfare to receive questions from the field. All*

GOAL 1: PROFESSIONALIZE AND STRENGTHEN THE TRAINING INFRASTRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
		training managers in the trainer network are invited to a quarterly web based Q&A training meeting to share training information. ***Year three.*** *The peer network remains in place as does the formalized process for the Office of Child Welfare to receive questions from the field. All training managers in the trainer network are invited to web based Q&A training meetings to receive training information.* 3. Establish a workgroup to assist in the planning and delivery of the semi-annual trainer meetings. *Year one and ongoing. Due to staff changes, this needs to be moved to year three.* ***Year three.*** *This has not been completed yet, but there are plans for a trainer meeting in October 2017.*
Initiative 1.6: Leadership and Guidance The current training unit has one supervisor solely dedicated to training and two specialists, each partially dedicated to training. Supporting information and data: The National Staff Development and Training Association (NSDTA) was established in 1985 as an affiliate of the American Public Human Services Association for the purpose of supporting persons responsible for human services training at all levels of government. The mission of NSDTA is to build professional and organizational capacity in the human services field. As one of its functions, the NSDTA	The training unit has the capacity to administer a statewide training program and uphold an effective and efficient infrastructure for training (pre- and in-service curricula; supervisory and specialty track training; and FSFN training). The unit provides: • technical assistance to the Department's regions, the community-based care agencies, and the sheriff offices • staff statewide training workgroups who assist with the five-year plan goals	1. Request budget allocation for five additional full-time positions to be housed in the training unit at headquarters (one additional specialist, one training administrator, and the three instructional designers mentioned in 1.3).The training unit is comprised of one supervisor; three curriculum developers; one training administrator and three training specialists. ***Year Two.*** *Two additional specialists were added to the training unit at headquarters in March 2016. One specialist is involved in training development and one specialist is involved in training funding and training initiatives.* ***Year three.*** *The training unit continues to consist of a training manager, a curriculum designer, and two*

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GOAL 1: PROFESSIONALIZE AND STRENGTHEN THE TRAINING INFRASTRUCTURE		
Current State	**Future State**	**5-Year Action Plan**
researches and makes recommendations for frameworks, models, and competencies required for effective staff development and training programs. Currently, there are 12 "competency clusters" recommended for effective child welfare training infrastructure: 1. Administration 2. Communications 3. Course design 4. Evaluation 5. Group dynamics/process 6. Instructional techniques 7. Learning theory 8. Manpower planning 9. Person/organization interface 10. Research and development 11. Training equipment and materials 12. Training needs analysis	• communication to the field to apprise trainers of current trends in training practices • annual meetings for the statewide network of trainers • review of the annual training reports to ensure alignment with the practice model and the CFSP goals • development and administration of the annual needs assessments	*specialists. There are plans to add additional curriculum design staff in year four.* 2. Recruit and hire for the new positions. *Year three.* ***Year three.*** *No new staff were recruited and hired in year three, but there are plans to recruit and hire additional curriculum design staff in year four.*

GOAL 2: PROMOTE A CULTURE OF CAREER-LONG LEARNING		
Current State	**Future State**	**5-Year Action Plan**
Initiative 2.1: Career Ladders / Specialty Tracks / Career-Long Curricula Career ladders vary. Some areas of the state enjoy well-structured, clear career ladders, while other areas offer mediocre ladders or lack professional advancement opportunities. Some pockets of the state have informal specialty tracks for Child Welfare Professionals. There is no	Florida recruits individuals who are well suited for working in the child welfare system. Supervisors have a variety of tools to use during application reviews and interviews of applicants. New hires are presented with a clear, structured career ladder that specifies general career progression, based on	1. Create a workgroup. *Year two. Move to year three.* ***Year three.*** *Exploration has begun to contract with a university to establish and maintain a child welfare advisory committee to make decisions regarding pre-service training, in-service training, and ongoing professional development.*

GOAL 2: PROMOTE A CULTURE OF CAREER-LONG LEARNING		
Current State	**Future State**	**5-Year Action Plan**
statewide program for specialty learning or certification. All new employees are sent to pre-service training. Beyond pre-service, a wide variety of in-service is offered, depending upon which agency, and where the new employee is employed. There is no statewide systematic training on topics such as psychotropic medications, behavioral health, the Indian Child Welfare Act, and disaster planning. All certified staff must have 20 hours of ongoing education each year (content and topics not specified). Supporting information and data: • A recent report from the Florida legislature's research agency indicated that the turnover rate for child protective investigators is 20% and 30% for case managers. Other reports indicate higher rates depending on how turnover is defined. • Of the 138 respondents to the trainer survey, 58% indicated that the career ladder is "excellent" (a very clear, structured career ladder is in place) or "good" (a career ladder is in place but the structure is somewhat lacking). The remainder of the respondents indicated that the career ladder is only "okay" or poor. See also SACWIS findings Appendix D, SARRS Findings and Appendix E Overview of Community-Based Care Training (DCF intends to examine the listing of training topics providing by the community based care agencies to note trends and possible statewide application)	established competencies. This includes learning opportunities for specialty tracks and in-service courses (outlined in Florida statute) to complete during their first years of employment. In-service training requirements tor on-going education include topics such as psychotropic medications, behavioral health, the Indian Child Welfare Act, and disaster planning.	2. Explore current career ladders and corresponding in-service training requirements (a standardized core set of long-term, in-service courses determined by the needs of Child Welfare Professional practice, the goals of the CFSP, and findings of continuous quality improvement data - and that range from foundational level to advanced practitioner level within a chosen track) and specialty tracks. ***Year two**. Move to year three.* ***Year three**. This will be further explored after a child advisory committee is established.* 3. Identify a variety of the best recruitment tools and strategies and offer them as examples for use at the regional level. ***Year two.** Move to year three.* ***Year three.** This will be further explored after a child advisory committee is established.* 4. Pursue legislation mandating uniform training requirements and minimum performance expectations for all child protective investigators and case managers in Florida. *Year three and four. Move to year four* 5. Pursue legislation mandating skills and policy training specific to child abuse and neglect investigations within the first years of employment. *Year three and four. Move to year four.*

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GOAL 2: PROMOTE A CULTURE OF CAREER-LONG LEARNING		
Current State	**Future State**	**5-Year Action Plan**
Initiative 2.2: Supervisor Professional Development The Department is currently moving away from a compliance-driven supervision model to a coaching and consulting supervision model. New pre-service curriculum for newly hired supervisors has been developed. There are significant differences in the frequency of supervisor trainings offered statewide. There is no standard in-service supervisor curriculum. Supporting information and data: • Survey responses from 138 trainers indicates that 37% of the training entities statewide offer supervisor-specific training very frequently (over 6 classes per year); 23% offered them frequently 4-6 times per year; and 33% offered them less than frequently (1-3 times per year). • Both Child Welfare Professionals and the literature identify the importance of the supervisory role in achieving desired service and organizational outcomes. The Children's Bureau has identified child welfare supervisors as "a critical focal point for the successful achievement of agency goals and caseworker practices that strengthen families." Due to the vital role they play in the child welfare organization, there is also increasing recognition in the literature of the need to provide training to supervisors and to provide extensive support to them as they carry out their roles (Strengthening Child Welfare Supervision, NCWRCOI, 2007).	Supervisors are the linchpin of practice. The instructional designers in the training unit develop advanced supervisor training for experienced staff. The headquarters training unit offers regular "lunch-and-learn" trainings that managers use with their frontline child welfare supervisors. The trainings are reinforced with a variety of fast, easy-to-administer training activities sent out through e-mail and survey tools. These trainings supplement the new supervisor pre-service curricula and focus on topics such as: a) common issues in supervising child welfare staff b) using data to improve the child welfare unit's effectiveness c) effectively providing performance feedback to employees d) recognizing strengths and improvements made e) coaching for improvement	1. Pursue legislation mandating uniform training requirements and minimum performance expectations for all child welfare supervisors in Florida. *Year three and four.* ***Year three.*** *This has not been completed and we would like to remove it from the plan. The proficiency process has been implemented for Department of Children and Families supervisors at all levels to ensure adherence of fidelity to the Florida Child Welfare Practice Model and to ensure child safety threats are addressed with the sense of urgency needed. A proficiency process for case management staff is planned.*

GOAL 3: FULLY INTEGRATE TRAINING INTO THE CONTINUOUS QUALITY IMPROVEMENT PROCESS		
Current State	**Future State**	**5-Year Action Plan**
Initiative 3.1: Continuous Improvement of Training There is no formal evaluation method to assess the quality of training being conducted across the state. Each community-based care agency submits semi-annual reports that capture all training courses. The report does not include evaluative information. The current training tracking system is under-utilized and incomplete. Supporting information and data: When asked to check all that apply regarding how the effectiveness of training programs are evaluated, 137 trainers reported: • 63% checked "some courses have pre- and post-tests • 35% reported "trainees and supervisors are interviewed after the training program" • 88% use evaluation forms • 32% indicate "practice measures are captured before and after the training program	One of the training unit's specialists is responsible for tracking and reviewing statewide programs to ensure they meet established criteria for: a) quality; and b) support of the CFSP goals and objectives. The training unit has established university partnerships to conduct level two (learning) and three (behavior) evaluations of large-scale curricula such as pre- and in-service and those designed to support major system or methodology changes.	1. Increase capacity and reporting capabilities of existing training tracking system. Amend provider contracts to include mandatory usage of the system by each employee. ***Year one and two.*** *Dismantling ancillary systems has encouraged the increased use of the FSFN tracking system.* ***Year three.*** *The training tracking system in FSFN allows users to input completed trainings, but does not have the capability to provide a statewide report on the trainings received. This has led many agencies to depend on other learning management systems. A better way to track and report trainings is being explored.* 2. Establish quality criteria for training programs. *Year three.* ***Year three:*** *The Florida Institute for Child Welfare is developing an evaluation method for the Pre-Service curriculum to use in the Fall of 2017.* 3. Establish criteria for determining whether trainings support the CFSP goals and objectives. *Year two.* ***Year three:*** *This has not yet been developed.* 4. Initiate the bid process to identify potential university partners to conduct evaluations of large-scale curricula. ***Year one.*** *A bid process is not needed. Part of the Florida Institute for Child Welfare's*

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GOAL 3: FULLY INTEGRATE TRAINING INTO THE CONTINUOUS QUALITY IMPROVEMENT PROCESS		
Current State	**Future State**	**5-Year Action Plan**
		responsibilities is to conduct a review of the pre-service training curricula. Completed. 5. Create "annual training review" procedures for reviewing a sample of courses developed at the local level for quality and support of the CFSP goals and objectives and review of the training program in general. *Year four*

GOAL 3: FULLY INTEGRATE TRAINING INTO THE CONTINUOUS QUALITY IMPROVEMENT PROCESS		
Current State	**Future State**	**5-Year Action Plan**
Initiative 3.2: Strengthen the Link Among Training, Data, and Quality Assurance Only pockets of the state have processes for systematically using quality assurance review findings and other assessment data to inform training.	Established statewide processes for systematically using quality assurance findings and other assessment data to inform training.	1. Examine practices around the state. ***Year one and two.*** *In year one a process was initiated to establish Critical Child Safety Practice Experts (CCSPE) in Florida's Child Welfare Practice Model. These experts will go through a proficiency process in year two to establish them as experts in the new practice. This will assist the state in examining practices around the state and assist in the development of future trainings.* ***Year two:*** *Over twenty CCPEs throughout the state have successfully completed the proficiency process and are now experts in Florida's Child Welfare Practice Model which will assist the state in examining practices and in the development of future trainings.* 2. Identify promising practices. *Year two. Move to year three.* ***Year three.*** *This has not yet been done in a systematic way, but will be completed more systematically as a structured approach to developing a statewide training plan and local training plans is implemented.* 3. Share and promote promising practices. *Year two and ongoing. Move to year three and ongoing* ***Year three.*** *See above.*

Appendix E2.

CBC Training Expenditures

Florida's Child and Family Services Plan 2015-2019

Training Plan

Appendix E2. Community-Based Care Training **Expenditures**

	BBCBC	CBCS	CBCCF-OO	CBCCF-Sem	CFC	ChildNet	CNSWFL	CPC	ECA-H	ECA-PP
TRPIS Training Expenditures - **2013**	437,820	159,564	297,532	53,673	306,112	448,366	359,781	181,954	424,416	351,202
Case Management	13,657,177	8,870,272	22,317,356	4,655,967	13,198,242	22,408,108	12,774,668	10,988,060	27,503,247	22,627,128
% Case Mgt to Training	3.21%	1.80%	1.33%	1.15%	2.32%	2.00%	2.82%	1.66%	1.54%	1.55%
GRAND TOTAL	31,789,118	21,045,773	49,801,481	11,223,190	38,349,055	57,783,137	29,315,743	29,547,199	65,518,756	60,261,169
% Total expenditures to Training	1.38%	0.76%	0.60%	0.48%	0.80%	0.78%	1.23%	0.62%	0.65%	0.58%
TRPIS Training Expenditures - **2012**	439,325	215,133	292,443	86,829	336,285	497,345	328,085	109,470	482,220	518,585
Case Management	13,718,929	9,112,446	22,547,430	5,711,757	12,809,834	22,404,625	11,225,796	10,752,704	22,856,245	30,589,271
% Case Mgt to Training	3.20%	2.36%	1.30%	1.52%	2.63%	2.22%	2.92%	1.02%	2.11%	1.70%
GRAND TOTAL	31,236,620	20,561,192	51,261,915	12,865,908	38,444,996	61,371,183	26,154,807	28,851,681	56,007,847	66,004,970
% Total expenditures to Training	1.41%	1.05%	0.57%	0.67%	0.87%	0.81%	1.25%	0.38%	0.86%	0.79%
TRPIS Training Expenditures - **2011**	440,833	271,390	324,766	94,662	296,955	631,336	309,336	148,080	483,090	526,687
Case Management	13,062,889	9,608,833	23,048,710	5,686,090	13,276,457	23,140,836	10,205,183	10,309,251	21,557,835	28,430,397
% Case Mgt to Training	3.37%	2.82%	1.41%	1.66%	2.24%	2.73%	3.03%	1.44%	2.24%	1.85%
GRAND TOTAL	30,571,802	21,172,819	52,094,641	12,477,876	37,805,269	64,831,613	23,660,312	27,968,012	52,922,620	64,994,792
% Total expenditures to Training	1.44%	1.28%	0.62%	0.76%	0.79%	0.97%	1.31%	0.53%	0.91%	0.81%

	FFN-Lakeview	FSSNF	Heartland	KCI	KFF	Our Kids	PSF	St Johns	UFF	YMCA	Total
TRPIS Training Expenditures - **2013**	538,522	317,155	319,572	512,114	15,235	475,950	333,629	36,826	376,448	145,607	6,091,477
Case Management	16,182,455	15,613,143	15,827,788	23,170,451	3,104,257	35,234,234	11,736,996	2,160,529	12,285,844	11,641,757	305,957,679
% Case Mgt to Training	3.33%	2.03%	2.02%	2.21%	0.49%	1.35%	2.84%	1.70%	3.06%	1.25%	1.99%
GRAND TOTAL	38,137,028	48,999,876	40,770,853	43,230,881	6,280,164	94,804,085	28,115,849	4,494,764	25,149,569	24,304,434	748,902,124
% Total expenditures to Training	1.41%	0.65%	0.78%	1.18%	0.24%	0.50%	1.19%	0.82%	1.50%	0.60%	0.81%
TRPIS Training Expenditures - **2012**	543,616	283,637	268,647	544,057	13,155	343,528	425,373	41,646	378,106	121,059	6,268,543
Case Management	16,266,973	15,349,892	16,380,772	23,057,973	2,910,231	36,280,238	11,225,474	2,119,443	12,681,664	12,186,745	310,188,442
% Case Mgt to Training	3.34%	1.85%	1.64%	2.36%	0.45%	0.95%	3.79%	1.96%	2.98%	0.99%	2.02%
GRAND TOTAL	36,826,633	46,899,132	41,685,079	42,742,986	5,832,408	94,905,616	29,158,160	4,704,547	24,257,426	24,448,783	744,221,890
% Total expenditures to Training	1.48%	0.60%	0.64%	1.27%	0.23%	0.36%	1.46%	0.89%	1.56%	0.50%	0.84%
TRPIS Training Expenditures - **2011**	472,069	127,174	346,253	590,471	8,831	699,249	368,233	19,147	182,225	120,800	6,461,588
Case Management	15,293,187	13,599,123	17,501,216	23,312,369	2,464,066	41,304,479	11,707,959	2,071,213	12,616,380	12,289,098	310,485,570
% Case Mgt to Training	3.09%	0.94%	1.98%	2.53%	0.36%	1.69%	3.15%	0.92%	1.44%	0.98%	2.08%
GRAND TOTAL	35,654,108	43,026,142	42,413,723	44,266,851	5,380,926	99,443,737	28,564,514	4,616,482	23,663,255	23,944,122	739,473,614
% Total expenditures to Training	1.32%	0.30%	0.82%	1.33%	0.16%	0.70%	1.29%	0.41%	0.77%	0.50%	0.87%

% Case Mgt to Training Dollars		% Total Exp to Training Dollars	
0.49%	3.33%	0.24%	1.50%
0.45%	3.79%	0.23%	1.56%
0.36%	3.37%	0.16%	1.44%
1.19%		0.81%	
2.02%		0.84%	
2.08%		0.87%	

Appendix E3.

CPI Training Allocation

Training Plan

Appendix E3. CPI Training Allocation

Child and Family Services Plan Child Protective Investigations Appropriations History					
Approved Operating Budget as of July 1	**Fiscal Year**				
Program Activity	**2009-2010**	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**
DEPARTMENT					
CHILD PROTECTION - INVESTIGATIONS (DEPARTMENT)*	$ 99,252,777	$ 99,791,110	$ 100,673,075	$ 109,896,757	$ 111,777,077
CHILD PROTECTION - INVESTIGATIONS (DEPARTMENT) - Salaries and Benefits Category ONLY*	$ 85,576,323	$ 86,262,481	$ 87,370,189	$ 90,470,889	$ 92,038,373
CHILD PROTECTION - INVESTIGATIONS TRAINING (DEPARTMENT)	$ 2,761,077	$ 2,758,794	$ 2,758,794	$ 2,533,297	$ 2,533,297
SHERIFF OFFICES					
CHILD PROTECTION - INVESTIGATIONS (SHERIFF)	$ 47,491,157	$ 47,491,154	$ 47,491,154	$ 46,985,592	$ 49,975,592
CHILD PROTECTION - INVESTIGATIONS TRAINING (SHERIFF)	$ 991,046	$ 993,328	$ 993,328	$ 919,825	$ 919,825
Grand Total	**$ 150,496,057**	**$ 151,034,386**	**$ 151,916,351**	**$ 160,335,471**	**$ 165,205,791**
*NOTE: Child Protection - Investigations (Department) appropriations do not include the following indirect cost (overhead) rates:	16.50%	16.09%	15.77%	12.84%	12.84%
state CPIs (1633 positions) $1,551.31 per position			3%	3%	3%
sheriff			2%	2%	2%
Source: ASB Master Report as of April 11, 2014					

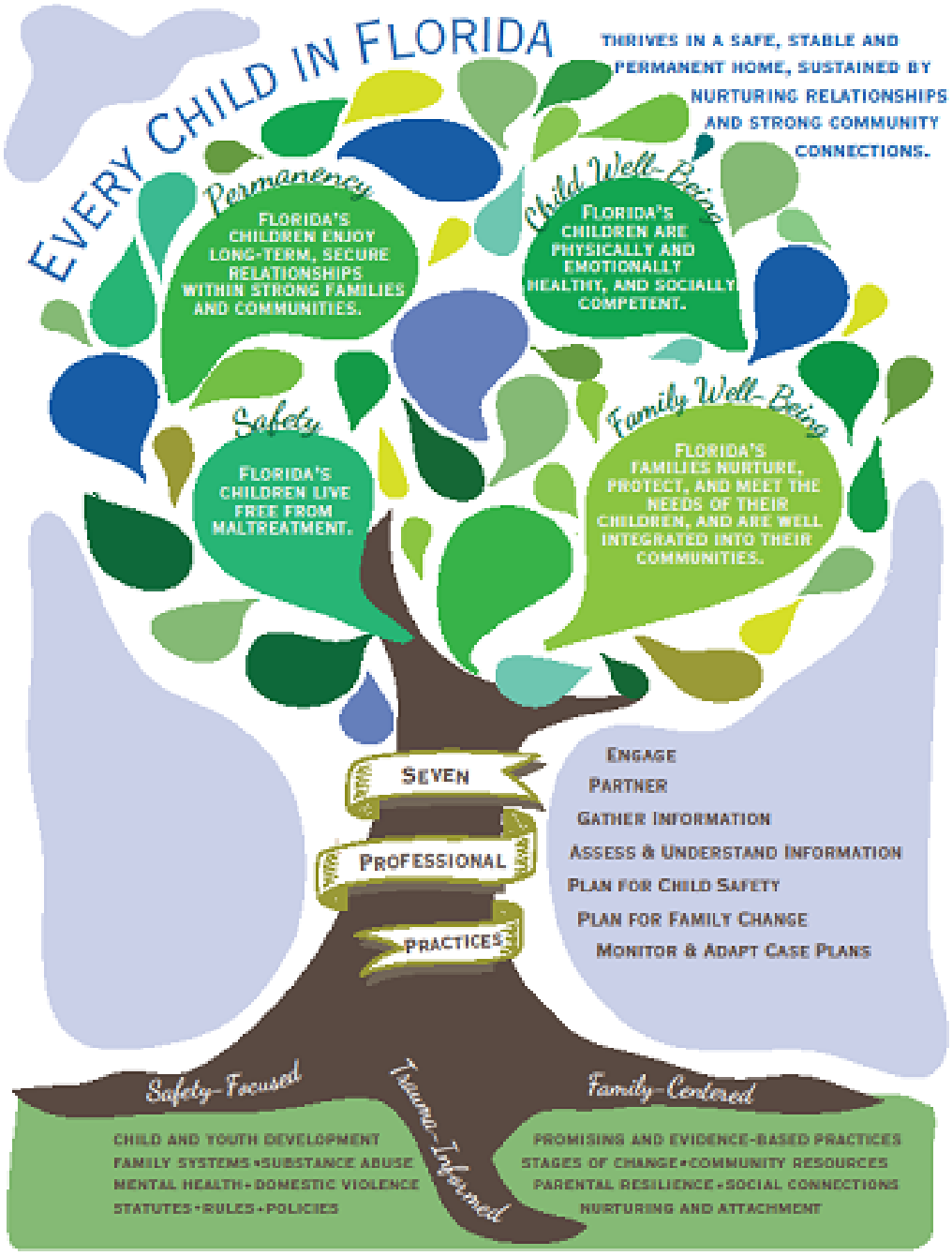
Appendix E4.

Practice Model

Florida's Child and Family Services Plan 2015-2019

Training Plan

Appendix E4. Practice Model



FLORIDA'S CHILD WELFARE PRACTICE MODEL

Florida's Child Welfare Practice Model

Vision

Every child in Florida thrives in a safe, stable and permanent home, sustained by nurturing relationships and strong community connections.

Goals

Florida's child welfare professionals seek to achieve these goals:

- **Safety.** Florida's children live free from maltreatment.
- **Permanency.** Florida's children enjoy long-term, secure relationships within strong families and communities.
- **Child Well-Being.** Florida's children are physically and emotionally healthy, and socially competent.
- **Family Well-Being.** Florida's families nurture, protect, and meet the needs of their children, and are well integrated into their communities.

Practices

To achieve these goals, Florida's child welfare professionals use a safety-focused, family-centered and trauma-informed approach that includes these key practices:

- **Engage the family:** Build rapport and trust with the family and people who know and support the family. Empower family members by seeking information about their strengths, resources and proposed solutions. Demonstrate respect for the family as the family exists in its social network, community and culture.
- **Partner with all involved:** Form partnerships with family members and people who know and support the family. Partner and share information with relative caregivers and foster and adoptive parents. Include parent and other caregivers in case decision-making. Lead and facilitate partnership with all involved parties to achieve optimum communication, clear roles and responsibilities, and mutual accountability.
- **Gather information:** Gather information from the family members and other team members throughout the course of interventions to gain insight into solutions that might work for family members. Update information as underlying issues, including trauma histories, are identified and as the family situation changes.
- **Assess and understand information:** Assess the sufficiency of information gathered. Identify and, whenever possible, reconcile unsupported impressions and observations or unverified statements regarding family functioning. Ensure all team members have a shared understanding of both risk and safety information and how this information informs interventions.
- **Plan for child safety:** Develop and implement, with the family and other partners, short-term actions to keep the child safe in the home or in out-of-home care. For a child in temporary care, identify the circumstances within the child's family that must exist for the child to be returned home safely with an in-home safety plan.
- **Plan for family change:** Work with the child, family members, and other team members to identify appropriate interventions and supports necessary to achieve child safety, permanency and well-being. Identify services to help the child recover from the effects of child maltreatment and trauma, and to restore typical development to the extent possible. Seek to identify what is needed for the family members and their support network to succeed in maintaining positive changes over the long term. Seek the caregivers' expertise in case planning and service delivery.
- **Monitor and adapt case plans:** Link family members to services and help them navigate formal systems. Troubleshoot and advocate for access to services when barriers exist. Modify safety actions and family case plans as the needs of family members change. Support the child and family members with transitions, including alternative permanency options when reunification cannot occur.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

THE SEVEN PROFESSIONAL PRACTICES: *What* child welfare professionals do.

THE SAFETY METHODOLOGY: *How* they do it.

THE GOALS AND VISION: *Why* they do it.

SEVEN PROFESSIONAL PRACTICES

Operationalized Using the Safety Methodology

Engage: The family is the primary point of communication, involvement and decision-making. The *Information Collection Protocol* for investigators and *Standards of Intervention* for case managers provide uniform processes that result in the ability to engage with the family and those who know the family. The uniform processes give parents information that empowers them, and seeks assistance from the family to gather sufficient information to complete the *Family Functioning Assessment* and (for unsafe children) the safety planning, *Family Functioning Assessment - Ongoing* and case planning. Engagement is essential to the development of the *Case Plan*, which includes goals for what must change, related to enhancing *Caregiver Protective Capacities* and the identification of treatment services. The case manager continues to engage the family to facilitate the needed change.

Partner: Partnering occurs throughout the time a child welfare professional works with the family. Child welfare professionals partner with the family, the family's network, other professionals and community partners to achieve understanding of family dynamics and develop safety decisions and actions, including safety planning and management, case planning and progress evaluation. The partnering process promotes commitment and accountability of the family and all team members toward common goals for the family.

Gather information: Sufficient, relevant information-gathering is the most essential ingredient for effective decision-making. Information is gathered through the information standards, referred to as the *Six Information Domains*, which frame what must be known about children and caregivers to inform effective decision-making. These *Six Information Domains* live within the *Family Functioning Assessment*. The *Six Information Domains* are: maltreatment; circumstances surrounding maltreatment; child functioning; adult functioning; general parenting; and parental discipline. Through the collection of this information, the child welfare professional "creates a picture" of the pervasive functioning occurring among adults and children within the family. The "picture" represents a merging of crucial information which reveals: the presence or absence of danger threats to child safety; the vulnerability of children; the level of caregiver protective capacities; the sufficiency of safety plans; the evaluation of case plan progress; and the assessment of risk. Information-gathering begins at the Florida Abuse Hotline and continues during the investigation and throughout ongoing case management for unsafe children.

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The Seven Professional Practices:
Operationalized Using the Safety Methodology

Assess and understand information: When relevant, sufficient information is gathered, assessed and analyzed to inform the danger assessment of the children and the actuarial risk assessment of future harm. Impending danger is qualified and understood through meeting all five *Danger Threshold Criteria*: (1) the child is vulnerable, (2) family conditions are out of control, (3) family conditions are likely to have a severe effect, (4) the danger is imminent, and (5) the danger is observable. When information in the *Six Information Domains* clearly supports an active impending danger threat that meets the *Danger Threshold Criteria*, and there is no one in the household with the caregiver protective capacities to manage the danger, the child is determined to be unsafe. A clear understanding of family functioning informs case plan outcomes developed to change behavior by enhancing diminished caregiver protective capacities. Several assessment tools are used throughout the life of the case: *Present Danger Assessment*; *Family Functioning Assessment*; the SDM® *Risk Assessment Tool*; *Family Functioning Assessment - Ongoing*; *Ongoing Family Functioning Progress Update*; SDM® *Family Risk Re-Assessment* and SDM® *Family Risk Reunification Assessment*.

Plan for child safety: There are two times when safety planning is needed. When a child is found to be in present danger, a *Present Danger Plan* is put in place to control present danger threats and to allow time for sufficient and relevant information collection through the *Family Functioning Assessment* process. When an investigator concludes at the end of the *Family Functioning Assessment* a child is unsafe, an *Impending Danger Safety Plan* is developed. Developing a sufficient *Impending Danger Safety Plan* to control and manage impending danger that is the least intrusive is completed through an immediate intervention called *Safety Planning Analysis*. Safety plans are managed by the agency. When a case is transferred from investigations to ongoing case management, the management of the *Impending Danger Safety Plan* is transferred at the same time and continues to occur through the life of the case. In addition, the *Safety Planning Analysis* is used for children with an out-of-home *Impending Danger Safety Plan* to create *Conditions for Return* for these children to return home with an in-home *Impending Danger Safety Plan*.

Plan for family change: Information gathered through the *Family Functioning Assessment - Ongoing* results in the development of case plan outcomes related to what must change to demonstrate enhanced *Caregiver Protective Capacities* addressing impending danger threats and *Child Needs*. The *Case Plan* includes specific, measurable, attainable, reasonable and timely outcomes that are developed jointly with the family, and the services associated with the outcomes. It is the "roadmap" or method by which change will be addressed.

Monitor and adapt case plans: The *Ongoing Family Functioning Progress Update* is a formal and ongoing intervention that occurs on a regular basis following the development of the family's *Case Plan*. It is intended to provide a standardized approach to measuring progress for enhancement of *diminished Caregiver Protective Capacities* as they relate to the impending danger threats and *Child Needs*, safety plan sufficiency and motivational readiness to change. Case plans are adapted as progress is made to further promote change. Caregiver progress is reflected and documented in the updated *Six Information Domains*, which inform the *Ongoing Family Functioning Progress Update*.

Appendix E5.

Overview of Training

Appendix E5
OVERVIEW OF TRAINING

This overview summarizes training data submitted by all Community-Based Care lead agencies, Sheriff's Office grantees, Children's Legal Services and the Department of Children and Families. During the year, the Florida Department of Children and Families and its partner agencies offered approximately 10,279 training activities or events to 82,525 attendees. This included approximately 225 Core and Specialty track Pre-Service trainings. During this time period a total of 26,415,983 Title IV-E and Title IV-B funds were spent on training.

The population of trainees included foster and adoptive parents; child protective investigators; foster care and adoption case managers; licensing and independent living specialists, children's legal services staff, services providers and other staff of state or local agencies administering the Title IV-E State Plan. The tables below show In-Service data broken down by audience, course type and training settings. Totals vary across tables because of missing data.

Table 1: Description of FY 2016 Audience

Audience Group	Number of Participants	Percentage
Case Management	50359	61.02
Child Protective Investigators	8119	9.84
Children's Legal Services	2711	3.29
Foster and Adoptive Parents	6871	8.33
Licensing Staff	891	1.08
Mixed	27	0.03
Service Providers	8136	9.86
Undetermined	5411	6.56
Grand Total	82525	100.00

Table 1 shows the numbers of individuals who received training in 2016, by stakeholder groups. Once again, in 2016, the case management group was the largest consumer of trainings offered, followed by service providers and child protective investigators. It is important to note that service providers group includes several categories of trainees. So, one could say that child protective investigation was really the second largest consumer group.

Table 2: Trainee Participation by Title IV-E Function

Title IV-E Admin Function Category	Number of Training Activities Provided	Percentage
AFCARS System	96	0.12
Assessment	6,876	8.33
Case Review System	2	0.00
Child Abuse and Neglect Issues	9,306	11.28
Child Development	1,788	2.17
Communication Skills	3,067	3.72
Cultural Competency	294	0.36
Domestic Violence	1,373	1.66
Effects of Separation	23	0.03
Ethics	2,904	3.52
Ethics-Q10	409	0.50
First Aid	729	0.88
Foster and Adoptive Parents	6,641	8.05
Independent Living	637	0.77
Job Performance Enhancement Skills	5,178	6.27
Mental Health	3,149	3.82
Permanency Planning	2,096	2.54
Preserving Families	1,926	2.33
Referrals to Services	1,306	1.58
SACWIS	1,798	2.18
Safe Driving	881	1.07
Social Work Practice	14,202	17.21
State Agency Personnel Policy and Procedures	5,507	6.67
Stress Management	542	0.66
Substance Abuse	787	0.95
Supervisory Skills	1,679	2.03
Team Building	389	0.47
Title IV-E Policies	553	0.67
Visitation/Family Time	41	0.05
Worker retention	423	0.51
Worker Safety	3,936	4.77
Undetermined	3,987	4.83
Grand Total	**82,525**	**100.00**

Table 2 shows the distribution of trainees by Title IV-E function category. In 2016, the functions with the most participation were, in order of importance, (1) social work practice; (2) child abuse and neglect issues; (3) assessment; (4) foster and adoptive parents; and (5) state agency personnel policy and procedures.

Table 3. Training Events Offered by Audience Groups

Audience Group	# of Trainings	Percentage
Case Management	6,650	66.45
Child Protective Investigators	659	6.58
Children's Legal Services	90	0.90
Foster and Adoptive Parents	517	5.17
Licensing Staff	171	1.71
Mixed	3	0.03
Service Providers	1,167	11.66
Undetermined	751	7.50
Grand Total	**10,008**	**100.00**

Table 3 shows the distribution of In-Service training events by audience group. In 2016 case management had the highest number of trainings, followed by service providers and child protective investigators.

Overall, 2016 training data shows higher numbers of training events and trainee participation compared to 2015. However, patterns in attendance of trainee groups have not changed. The Department continues to believe that foster and adoptive parents are receiving more trainings than are being tracked and reported. Efforts are being made to address this situation including telephone consultations with Community-Based Care lead agencies and their Case Management Organizations.

Appendix E6.

2015-2016
Training List