California Citizen Review Panels

Annual Report for 2017-2018 Project Period

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Executive Summary

Citizen Review Panels (CRPs) were established by federal statute and implemented in 1996 as part of the Child Abuse Prevention and Treatment Act (CAPTA) to bring a citizen voice to the development and implementation of child welfare policies, procedures, and laws. The responsibilities of the CRP involve evaluating policies, practices, and procedures, assessing systemic barriers, and making recommendations to improve the child welfare system.

California historically met the CAPTA mandate by empaneling one statewide and two local county panels. In 2017, for the first time, the state of California established three statewide panels, the Prevention of Child Abuse and Neglect CRP, the Children and Family Services CRP, and the Critical Incidents CRP. The panels had broad latitude to select their focus area and make recommendations within each of the three subject areas.

The Prevention of Child Abuse and Neglect Citizen Review Panel

The Prevention CRP members began their work with an eye toward supporting a strategic direction to prevent child abuse and neglect in California. Educating, informing, and involving communities came to the fore as foundational concepts of an effective prevention system. California has a rich resource in its over 500 Family Resource Centers (FRCs) throughout the state that deliver on those concepts daily in their work with children and families in local communities. Much work has gone into developing a broadly collaborative vision for the FRCs, yet differences in structure and service delivery across California remain. While the state has made some contributions to support FRCs, integrating the FRCs as full partners with the California Department of Social Services (CDSS) more broadly, other child serving state agencies like mental health, public health, and county child welfare agencies, remains challenging.

FRCs, with consistent structure and practice, can and should serve as the scaffolding that holds up the state's prevention system

The Prevention Citizen Review Panel believes that FRCs, with consistent structure and practice, can and should serve as the scaffolding that holds up the state's prevention system. The panel's work this year focused, therefore, on encouraging CDSS and other child serving state and local agencies to support the FRCs as full partners and help position them as the foundation of California's prevention system.

The Panel explored the location, structure, and practices of FRCs by reviewing a web-based Prevention Partners Survey conducted by the Office of Child Abuse Prevention (OCAP) and delving more deeply into the Vehicles for Change, Volume II (V4C) vision. The panel agreed that their work this year will lend voice to this critical movement by:

● helping to position the FRCs as the key prevention strategy in California and

● promoting the statewide dissemination of the V4C framework.

Recommendations

The Prevention Citizen Review Panel recommends that:

1. CDSS recognize and promote FRCs as the priority delivery network of the state's prevention services.

2. CDSS identify and promote FRCs as stakeholders in relevant initiatives and projects across all child and family serving state agencies.

3. CDSS improve communication channels by including FRCs when the agency sends communications to counties, including FRCs in CDSS planning and system improvement initiatives, and promoting FRCs' involvement in the development of county prevention plans.

4. CDSS rely on FRCs as conduits to families and communities by involving FRCs in outreach.

5.CDSS continue to ensure that the child welfare field receives training and support in implementing the Vehicles for Change vision to strengthen and improve FRC structure and service delivery.

The Children and Family Services (CFS) Citizen Review Panel

The CFS panel decided to focus their work this year on quality casework practice. Members discussed ways in which quality casework practice that authentically engages families can help parents and their children reunify more quickly. One of the most critical caseworker decision points happens early in a placement episode and sets the tone for the case often for months to come. Workers are responsible to develop case plans that include planning for family time with their children (visitation). Research has shown that visitation between parents and their children is one of the key indicators of speedy reunification. The Children's Bureau's analysis of two rounds of

federal Child and Family Services Reviews across the country found the same.

Research has shown that visitation between parents and their children is one of the key indicators of speedy reunification

The Panel decided to learn more about how and when visitation plans are developed and what they contain. The panel explored how the level of supervision is determined, the frequency and the quality of visits, and updating visitation plans as the case progresses.

The panel learned that there is no state policy or guidance to county child welfare agencies around visitation. Despite the unique needs of children and families, when a child is placed, the majority of visitation plans routinely require supervised visits in the child welfare office. There are no standard criteria workers use to determine the level of supervision needed in visits and visitation plans are not regularly updated to step down supervision levels and increase time based on the changing circumstances of a case. Courts do play an active role in determining or overseeing visitation planning, depending on the county, but panel members reported that most often, court orders allow broad discretion to the child welfare agency to develop and update visitation plans

The Panel is concerned that there is no standardized statewide visitation policy or guidance. While CDSS reported to the Panel that visits should be determined on a case by case basis and should not be used as a reward or punishment, supervisors overwhelmingly reported that all visitation starts supervised in the office, that workers are making decisions based on local practice rather than being guided by policy, and that families must work their case plan to increase visitation time or have opportunities for unsupervised visitation time. The disparity in CDSS' description of best practices and actual local practice is broad.

Recommendations

The Children and Families Citizen Review Panel recommends that:

1. CDSS and the Judicial Council, appoint a joint task force, with representation from courts, advocates, child welfare, non-agency partners, foster parents, parents and former foster child stakeholders to improve visitation practice statewide by:

a. Conducting a scan, across counties, of current visitation practice, specifically, how visitation plans are developed, monitored, and updated on a regular basis, barriers counties face in providing adequate visitation, and whether

courts are including visitation considerations in their determination of reasonable efforts;

b. Reviewing research findings and best practice developed by other states and;

c. Based on that review, developing policy and guidance related to visitation to include:

i. development of case specific visitation plans with parents and caregivers;

ii. guidance on assessing the safety threat during a visit to determine the level of supervision needed, and

iii. policy that specifies workers are to discuss and update visitation plans at each required monthly visit by caseworkers with parents.

2. CDSS issue an All County Information Notice providing guidance on developing visitation plans, specifically noting that:

a. all families' needs and risks are unique and no county should have a standardized visitation protocol for all families, regardless of their individual needs and circumstances;

b. initial case planning meetings should dedicate sufficient time for development of a case specific visitation plan and;

c. visitation plans should be discussed and updated at every required monthly meeting between the caseworker and each parent.

3. CDSS review the visitation training provided through the Core Curriculum and ensure it is aligned with policy and guidance developed as a result of the joint task force and All County Information Notice, including specifics about developing and regularly updating family visitation plans based on whether the child can be safe during a visit.

The Critical Incidents and Child Fatalities Citizen Review Panel

In recent years, "Congress has recognized that child abuse and neglect fatalities are a complex, intractable problem requiring thorough analysis and well-informed solutions." Congress created the National Commission to End Child Abuse and Neglect Fatalities to fully study trends in fatalities and near fatalities nationwide and make recommendations to end them. The findings and recommendations of the National Commission bring to light some of the same concerns the Critical Incident Citizen Review Panel expressed about practice in California. The Panel chose to work on two issues of concern this year: mandated reporting of suspected child abuse and neglect and local and state child death review teams.

Mandated Reporting of Suspected Child Abuse and Neglect

In the experience of panel members, the failure of mandated reporters to report suspected child abuse and neglect can lead to a subsequent fatal or near fatal event. Issues of training for mandated reporters and consequences of failure to report were addressed by the panel.

In the experience of panel members, the failure of mandated reporters to report suspected child abuse and neglect can lead to a subsequent fatal or near fatal event

Adequate training of mandated reporters is critical. Training requirements across California are varied and inconsistent. Some are lengthy, some are as short as an eight-minute video. When reports of suspected abuse or neglect are made, child welfare agencies often do not get adequate identifying and descriptive information that allows them to locate a family and investigate the allegation.

Recommendations

The Critical Incidents Citizen Review Panel recommends that:

1. CDSS work with county child welfare agencies to train mandated reporters not only to recognize suspected child abuse and neglect but also to understand how to make a report that will rise to the level of a child protective services investigation, if appropriate.

2. CDSS work with institutions of higher education to include mandated reporter training in curricula that will result in students entering a field in which they will become mandated reporters (i.e. medical schools, law schools, social work programs, public health programs, corrections and law enforcement programs, teaching programs, nursing programs, and others).

3. CDSS work with the State Department of Education to ensure that all employees are trained uniformly as mandated reporters with minimum standards for those training programs. (for example, eight-minute videos to meet this mandate should not be allowed).

Child Fatality Review at the State and Local Levels

As the panel progressed in their work, child fatality and near fatality review at the state and local levels emerged as another significant concern the panel decided to explore. The panel learned that the state Child Death Review Team has been disbanded due to lack of funding.

Cross reporting requirements among child welfare, law enforcement, and coroners have also been suspended for the same reason.

Local review teams operate differently across the state. State level review by an internal CDSS team does not consider the findings of local review teams in reaching conclusions or reporting data. These and other concerns prompted the panel to make far reaching recommendations that the panel understands may not be in CDSS' ability to implement on its own. Given that the panel is dealing with the most difficult topic in child welfare, fatal or near fatal child abuse and neglect, the panel directed their recommendations to the entire system with the hope that coordinated, well-funded work on the state and county level can reduce and ultimately end child fatalities in California.

Recommendations

The Critical Incident Citizen Review Panel recommends that CDSS work with the Department of Public Health, the Department of Justice, and local child death review teams (hereinafter "the partners") to improve the process, data collection, and reporting of child abuse and neglect fatalities and near fatalities, to prevent them in the future.

The panel's specific and targeted recommendations to each state and local entity involved in the system to make these improvements can be found in the body of the report.

Background

Citizen Review Panels (CRPs) were established by federal statute and implemented in 1996 as part of the Child Abuse Prevention and Treatment Act (CAPTA) to bring a citizen voice to the development and implementation of child welfare policies, procedures, and laws. CRPs focus on matters throughout the continuum of the child welfare system. Their efforts must be rooted in data, analyzing trends, and providing valuable insights that inform those working within the system. CRPs are charged with making recommendations that will improve the lives of children and families throughout California.

Historically, California has empaneled one statewide and two local county panels. In 2017, for the first time, three statewide panels were established to address issues that affect the entire state.

Prevention of Child Abuse and Neglect CRP

The Prevention of Child Abuse and Neglect CRP examines ground -level child abuse and neglect prevention activities and makes recommendations on the state of prevention and early intervention practice.

Children and Family Services CRP

The Children and Family Services (CFS) CRP focuses on ground-level practices affecting children in foster care. Systemic reform recommendations made by existing committees informed the CFS CRP as they decided which intervention practices should be given priority for their work this year.

Critical Incident CRP

The Critical Incident (CI) CRP focuses on state and local issues related to child fatality and near fatality review. This year, their work was geared toward examining the functioning of the local child death review teams and CDSS' internal review team as the state child death review team has been disbanded.

Member Selection

CRPs bring together numbers of participants from diverse backgrounds and perspectives. CRPs should work to achieve common goals and objectives while respecting the diversity of members perspectives. CRPs should encourage constructive conversation while gathering ideas and recommendations to improve the child welfare system.

BPRAC accepted applications from all prospective members. In addition, BPRAC and OCAP recruited potential members to ensure each CRP is represented by members who have a full range of expertise in child abuse and neglect. Outreach was done through email blasts, the OCAP Newsletter, social media, and word of mouth. Targeted outreach was done to young people and families who had been involved in the system.

Panel Structure and Operations

Each CRP in California is supported and facilitated by Big Picture Research and Consulting (BPRAC), an independent, outside facilitator. BPRAC developed and completed the panel member selection process and planned, guided, and managed each CRP's quarterly meetings in consultation with the Office of Child Abuse Prevention (OCAP). Each panel operates under a flat structure with no committee chairs or officers. BPRAC facilitates each meeting and does not participate in panel voting.

Each panel met in February, April, and July of 2018. During the interim, panels participated in interim calls when needed and reviewed an array of reports, data, and other information related to their chosen topic(s). After drafting their final report and recommendations, the panels sought public comment electronically from a broad network of professional and lay system stakeholders. Incorporating stakeholder comments, and the panels' response, this final report is the culmination of their work.

The panels had broad latitude to select their focus area within each of the three subject areas

Topic Selection

The panels had broad latitude to select their focus area within each of the three subject areas. Each of the panels reviewed a system scan that identified reports and recommendations related to overall system improvement efforts in California, reviewed existing resources and initiatives, and engaged in a robust discussion to identify issues of concern to which they could lend voice.

The system scan focused on significant reports related to the California child welfare system. The panels assessed the actual implementation of ongoing and recommended child welfare systemic reform efforts. The panels' review included but was not limited to the following:

- Federal Round Three Child and Family Services Review results,
- Annual Progress and Services Report,
- California Child and Family Services Plan

● Indian Child Welfare Act Task Force Report

● CDSS Program Improvement Plan

● National Center for Fatality Review and Prevention--Spotlight on California

● Child Fatality Report (2014)

● OCAP's Strategic Plan 2015-2020

● Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Strategies (March 2016)

● California Penal Code

The review also leveraged BRPAC's knowledge of California child welfare systems, current research, and data trends and analysis, as well as a review of current policies and practices.

Prevention panel members decided unanimously to focus their efforts this year on consistency of implementation of Family Resource Centers (FRC) statewide. Following the same process, the Children and Family Services panel chose to explore the issue of visitation between children and their parents when children are placed in foster care and the Critical Incidents panel decided to focus on mandated reporting of child abuse and neglect and state and local child death review team processes and outcomes

The Prevention of Child Abuse and Neglect Citizen Review Panel

Background

The work of the Family Resource Centers in California has been building and evolving for over 20 years from service delivery hubs to networks of organizations meeting the needs of children and families, to promoting more evidenced based services, to harnessing the power of communities and residents working to improve systems. National standards for FRCs were created in the 1990s.

Over the years, FRCs have also served as laboratories for implementation of best practices

The most recent work specific to California, Vehicles for Change, Volume II, (V4C) tells the story of the evolution of California's FRCs since 2000. V4C is based on more than 100 interviews with a wide range of California professionals in the field, a review of research and evaluation, and models developed in other states. V4C describes the best practices and core elements of FRCs and has a call to action for the next phase of FRC development and roles. Principles and Standards, developed in 2016, stress continuous quality improvement and help centers evaluate and quantify success levels of their services. Over the years, FRCs have also served as laboratories for implementation of best practices. Some successful practices become embedded in the model, others come and go.

Panel Discussion

FRCs do not operate with a consistent structure, framework, or service delivery model. In fact, their greatest strength may also be their greatest weakness. The FRC model is flexible and nimble enough to respond to unique and emerging issues in the communities they serve, making it difficult to build a consistent structure or service delivery model statewide.

There is no baseline set of services an entity must provide to call itself an FRC. The state has made some contribution to support FRCs yet their integration as a full partner with county child welfare agencies, with CDSS, and with other child-serving state agencies (i.e., mental health and public health) has not yet occurred.

Inconsistent sharing of information from the state to the counties to the FRCs was noted as a concern. Most often, opportunities are identified at the state level and information is shared with the counties but goes no further. There may be opportunities for funding, training, and collaborative events about which the FRCs are unaware. For FRCs to be viewed as

full partners, communication needs to be consistent and frequent from the state level to the county level and back again, including FRCs when opportunities arise, when important information is being shared across systems, and when state or county improvement planning is underway.

Communities and policy makers may not be fully aware of the power that an FRC can bring to helping children, families and communities

Panel members shared that most policy-makers and people in local communities, if asked, could identify a list of services needed in their community but few, if any depending on their location, would be aware that the FRC in their community may already be offering those services or if funded, could be providing them. Communities and policy makers may not be fully aware of the power that an FRC can bring to helping children, families and communities.

Panel members discussed their views about the successes in V4C implementation to date. They noted that in some counties, hard built collaborations are being formed, philanthropic foundations have begun to support the vision, and messaging around the FRCs engaging the community and building public/private partnerships is strengthening.

Remaining challenges include:

- the implementation of the V4C vision because it is more a high-level vision than a road map;
- the need for strengthening state to county to local FRC communications;
- the need for FRCs to have stronger partnerships with county governments who can notify FRCs of funding opportunities and include FRCs as partners in planning, funding, and system reform efforts;
- inconsistent, unreliable and unstable funding; and
- the naturally occurring and differing developmental stages of the FRCs from emerging to established.

While Strategies 2.0, funded by the State Office of Child Abuse Prevention, is providing training on the vision, there is still no clear road map to move FRCs along the continuum from emerging to established as they mature as programs.

Report from the Field

To get a snapshot of FRC development and V4C implementation, the panel, through its facilitators, conducted seven interviews. Interviewees included FRC staff and support staff, a social service agency program manager, trainers for FRC leadership programs, and

others familiar with FRCs and V4C around the state.

Theme One: Familiarity and Purpose of Vehicles for Change

Interviewees familiar with Vehicles for Change reported that they used it as an onboarding tool with new staff to help bring them along on the philosophy and intention of FRCs. One interviewee disagreed, believing V4C is most appropriate for use at the director level.

Three FRC representatives used Vehicles for Change to communicate their vision and importance of their work with stakeholders. They shared that it was helpful to have OCAP funding.

Theme Two: Implementation of Vehicles for Change

All interviewees agreed that it is not possible to implement V4C on its own. They believe V4C is not to be used like an implementation checklist but as a philosophical guide to share the vision and purpose of an FRC and its historical evolutionary development. Interviewees said that part of the ongoing work of an FRC is determining how to implement and operationalize V4C in a way that is appropriate to the unique community each FRC serves.

Theme Three: Sharing the successes and Importance of FRCs

FRCs are working to incorporate data into their work. FRCs report they keep client databases and share both input and outcome data with various state organizations. Interviewees agreed that storytelling with data is the best way to highlight the importance of FRC work. All FRC representatives shared a desire to increase their data capacity and to have some universal measures to view their reach or impact on a state level.

Theme Four: Networking and Support among FRCs

FRC representatives shared that it is hard to connect with other FRCs within their region or around the state. All interviewees shared that partnerships with each other are key to the success of the work of FRCs. Most interviewees added that building external partnerships would also be easier if FRCs could leverage the learning of other FRCs who have experienced success.

Recommendations

The panel wishes to lend voice to the importance of primary prevention and of FRCs as the vehicles for promoting prevention, doing prevention work, and doing Family Strengthening work through their network's implementation of V4C. FRCs are completely aligned with OCAP's mission to shape policy, build community, and strengthen families so maltreatment is prevented. OCAP can act as a catalyst within and across CDSS and other child serving state agencies to position the FRCs as full partners in the state's efforts to prevent abuse and neglect. There are many directions the panel could have pursued in visioning this partnership. At the core is the need first for CDSS and other state agencies to view the FRCs as a key strategy and full partners, actively engaging them across the prevention continuum.

The Prevention Citizen Review Panel recommends that:

1. CDSS recognize and promote FRCs as the priority delivery network of the state's prevention services.

2. CDSS identify and promote FRCs as stakeholders in relevant initiatives and projects across all child and family serving state agencies.

The panel wishes to lend voice to the importance of primary prevention and of FRCs as the vehicles for promoting prevention

3. CDSS improve communication channels by including FRCs when the agency sends communications to counties, including FRCs in CDSS planning and system improvement initiatives, and promoting FRCs' involvement in the development of county prevention plans.

4. CDSS rely on FRCs as conduits to families and communities by involving FRCs in outreach.

5. CDSS continue to ensure that the child welfare field receives training and support in implementing the Vehicles for Change vision to strengthen and improve FRC structure and service delivery and support enhanced professionalism in the field.

The Children and Family Services Citizen Review Panel

Topic Identification

To select their focus area for this year, panel members reviewed a system scan of all relevant committees, commissions, reports, research, and other topical data related to services to children and families in the foster care system across California. The topics focused particularly on practice issues "on the ground." While the Panel could have selected any topic, they believed there were so many recommendations from different entities already in play in the state, that their work should explore whether any of them had, in fact, been implemented. The panel decided to focus their work this year on quality casework practice.

Child welfare caseworkers have an impact on practice at all levels and stages of a child welfare case. They are responsible for screening calls, investigating, and determining whether abuse or neglect has occurred. Once a case is substantiated and a child is removed from home, the worker's initial decisions set the direction for the case.

Members discussed ways in which quality casework practice that authentically engages families can help parents and their children reunify more quickly. One of the most critical caseworker decision points happens early in a placement episode and sets the tone often for months to come. Workers are responsible to develop case plans that include visitation plans. They are required to connect with parents and others to do so. While all the decisions by caseworkers are reviewed by courts and other review bodies and may change at any time during the case, family visitation plans in the majority of cases are not revisited.

The Panel … decided to focus their efforts on the issue of the frequency and quality of visits between parents and their children when their children are placed in foster care

Research has shown that visitation between parents and their children is one of the key indicators of speedy reunification. The federal Children's Bureau analyzed results of two rounds of the federal Child and Family Services Reviews across the country and found the same.

The Panel, therefore, decided to focus their efforts on the issue of the frequency and quality of visits between parents and their children when their children are placed in foster care. To aid in their exploration of practice, the Panel requested and considered information provided by CDSS along with other relevant materials.

Background

To assess practice related to visitation, the Panel looked first to the federal Child and Family Services Review measures. California is not in substantial conformity with any of the measures related to family engagement. In this third round of federal reviews, states are expected to be at a certain compliance level and California's levels, in the 30 – 50% range, were well below the expected standard.

The panel learned that there is no state policy on minimum standards for visitation

The panel met with CDSS representative, Turid Gregory-Furlong, Manager of the Concurrent Planning and Policy Unit, at the April and July meetings. This allowed the Panel to ask questions about state level policy and best practices related to visitation. The panel learned that there is no state policy on minimum standards for visitation and counties operate differently in terms of creating, managing, and updating visitation plans. The CDSS representative did outline, however, what she believed to be best practice in visitation planning and delivery.

1. Decisions about the amount of time, frequency, level of supervision, and location of visits should be based on the level of risk to the child during the visit and should also meet the child's developmental needs.

2. Plans should be updated regularly based on the parents' current circumstances.

3. Group care facilities are responsible for facilitating visits when a child is in placement.

4. The caseworker can and should request a "step down" in the level of supervision as soon as it is determined to be safe.

5. Visitation should not be used as a reward or punishment for compliance with the case plan.

6. Reports show that nearly 90% of all visits are supervised. CDSS reports that high caseloads and resources for supervising visits are a barrier to allowing for more visitation.

Report from the Field

Between April and July, Panel facilitators conducted interviews with six CDSS supervisors in different counties to provide a snapshot of current practice. Sixteen supervisors in 13 California counties, both urban and rural, were contacted. Thirteen responded and interviews with eight who had availability were scheduled. Six called-in to the scheduled interview. The number of interviews is not a representative sample of supervisors in the state although

comments were consistent across counties including the following themes:

Theme One – Visitation for All Families Starts as Supervised Visitation

Each supervisor shared that all visits start supervised in the child welfare office. Nearly all supervisors stated that initial visitation time is determined based on the best interest of the child and is dictated by local practices rather than a written policy. Some supervisors said decisions about visitation time are made entirely case-by-case because of the unique needs of each family. Other supervisors gave examples of how visitation time is determined.

Theme Two – All Visits Move to a Supervised Visitation Center After Initial Office Supervision

After initial visits in the office, all supervisors said that visits move to being supervised or monitored at a visitation center outside the child welfare agency and may then be moved to a park, restaurant, home or other location. Most supervisors said this decision was based on the worker's assessment of whether the parents are working their case plan. One supervisor said it was dependent on the relationship between the social worker and parent. Some supervisors said the timing was on a case-by-case basis, and others gave examples of how these decisions are made.

Theme Three – Barriers to Visitation

Supervisors identified a number of barriers to increasing visitation time. Multiple supervisors shared that coordinating schedules between school-age children and parents was the biggest barrier. One county shared that transportation was the biggest barrier, especially when parents are in residential treatment or live outside of the county. One county shared that the mental health and sobriety (both during the visit and whether parents have been sober for a predetermined period of time) were barriers to visitation but that the biggest barrier in this county is the weather. The supervisor shared that they are not comfortable sending children out in the rain unless the parent has a car for transportation. Two counties shared that funding was the biggest barrier that negatively impacts the availability of staff to supervise visits, facility space, and toys. One county said their biggest barrier is children not wanting to see their parents. One county said that there

are no barriers to increasing visitation “if the families are doing their part”.

The Panel believes that visitation should be a right and not a reward for working the case plan or a punishment for failing to do so

CDSS Information - July Panel Meeting

The panel met again with Ms. Gregory-Furlong at the July meeting. She provided input to the panel around questions that had arisen since she last spoke to them in April. She shared that the role of CDSS is to provide guidance to the county child welfare departments. Visitation planning is covered in the Core Curriculum for new caseworkers although the topic is covered in a generic way. The courts take an active role in oversight of visitation plans. When workers are not providing adequate or quality visitation, the courts, through their mandate to make findings that the agency is making reasonable efforts to provide services to allow children to safely return home, can issue a show cause order requiring the worker to appear and explain why they are not following the courts’ orders. It is unknown to what extent courts take this action on any negative “reasonable efforts” findings.

Visitation is tracked by the agency to ensure compliance but not necessarily to collect data on quality and levels of supervision. CDSS was not aware that the issue of parent/child visitation was being addressed in any of the current system improvement efforts at the state level. Los Angeles County and San Diego county are currently working on local collaborative efforts to improve visitation practice.

Recommendations

The Panel is concerned that there is no standardized statewide visitation policy or guidance. While CDSS reported to the Panel that visits should be determined on a case by case basis and should not be used as a reward or punishment, supervisors overwhelmingly reported that all visitation starts supervised in the office, that workers are making decisions based on local practice rather than being guided by policy, and that families must work their case plan to increase visitation time or have opportunities for unsupervised visitation time. The disparity in state guidance and local practice is broad.

The Panel believes that visitation should be a right and not a reward for working the case plan or a punishment for failing to do so. The importance of parent/child bonding is critical. California's lack of substantial conformity in Round Three of the Child and Families Services Review warrants a statewide solution.

Given that parents, children, the court, local agencies, lawyers, Court Appointed Special Advocates (CASAs), and foster parents, at a minimum, are all actively involved in visitation planning and execution, the Panel discussed the idea of a multi-systemic response to improve practice. Visitation must be determined based on what children and families actually need and not on what the county is willing or not willing to do.

The Children and Family Services Citizen Review Panel recommends that:

1. CDSS and the Administrative Office of the Courts, through the Court Improvement Program, appoint a joint task force, with representation from courts, advocates, child welfare, non-agency partners, caregivers, and family and child stakeholders to improve visitation practice statewide by:

a. Conducting a scan, across counties, of current visitation practice, specifically, how visitation plans are developed, monitored, and updated on a regular basis, barriers counties face in providing adequate visitation, and whether courts are including visitation in their determination of reasonable efforts.

The Panel is concerned that there is no standardized statewide visitation policy or guidance

b. Reviewing research findings and best practice developed by other states and;

c. Based on that review, developing policy and guidance related to visitation to include:

i. development of case specific visitation plans with parents and caregivers;

ii. guidance on worker assessment of the safety threat during a visit to determine the level of supervision needed; and

iii. policy that specifies workers are to discuss and update visitation plans at each required monthly visit by caseworkers with parents.

2. CDSS issue an All County Information Notice providing guidance on developing visitation plans, specifically noting that:

a. all families' needs and risks are unique and no county should have a standardized visitation protocol for all families, regardless of their individual needs and circumstances;

b. initial case planning meetings should dedicate sufficient time for development of a case specific visitation plan; and

c. visitation plans should be discussed and updated at every required monthly meeting between the caseworker and each parent.

3. CDSS review the visitation training provided through the Core Curriculum and ensure it is aligned with policy and guidance developed as a result of the joint task force and All County Information Notice, including specifics about developing and regularly updating family visitation plans based on whether the child can be safe during a visit.

The Critical Incidents and Fatalities Citizen Review Panel

Background

In the last several years, "Congress has recognized that child abuse and neglect fatalities are a complex, intractable problem requiring thorough analysis and well-informed solutions." Congress created the National Commission to End Child Abuse and Neglect Fatalities to fully study trends in fatalities and near fatalities nationwide and make recommendations to end them. The findings and recommendations of the National Commission bring to light some of the very same concerns this Panel has expressed about practice in California.

Topic Identification

At the first meeting of the Critical Incidents Citizen Review Panel in February 2018, participants, many of whom have been involved with child death review in California for many years, brainstormed issues of concern related to child abuse and neglect fatality and near fatality review to guide their work for the coming year. The Panel met in groups of two to discuss issues that resonated for each of them from their own experiences or in their review of a system scan prepared by the panel facilitators. Members then met in groups of four to do the same exercise and then as a whole group to select one issue to focus their attention on for the year.

Issues that arose during the group process were:

1. Failure of mandated reporters to report suspected child abuse and neglect;

2. Failure of child welfare agencies to investigate reports they receive;

3. Failure of child welfare agencies to complete an investigation when they do investigate and;

4. Re-abuse – incidents in which families have had previous contact with child welfare and a subsequent abuse is critical or fatal.

The panel reached consensus that failure of mandatory reporters to report suspected child abuse and neglect is a serious issue in need of system-wide reform

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The panel reached consensus that failure of mandated reporters to report suspected child abuse and neglect is a serious issue in need of system-wide reform. Instances of failure to report, in the panel members' experiences, have resulted in subsequent fatalities and near

fatalities so the decision was made to examine this further in the panel's work this year.

Sending new professionals into the field with an awareness of mandated reporter laws will most certainly have a positive effect on reporting

Information and Discussion

The Panel focused first on training for mandated reporters. The National Commission recommended that Congress impose training requirements for mandatory reporters in all states. Concern was raised by panel members that there is no consistent, standard training across California. Panel members shared that training can range from several hours to watching an eight-minute video. Concern was also expressed that unless mandated reporters understand the type of information child welfare needs to trigger an investigation, that reporters are not providing the agency with the amount and type of information that the agency needs to locate the family and determine whether an investigation is appropriate.

The Panel raised concerns about whether mandated reporters who fail to report are held accountable in any way. Members decided to hold this conversation until next year's work cycle and will request information about whether any mandated reporters have been prosecuted for failure to report.

The Panel was concerned about the fact that the mandated reporter training website was transitioning to another provider. Throughout the year, the Panel has followed the transition and is grateful to CDSS for ensuring not only that no content was lost but also that efforts are underway to develop specific training for specific populations.

The Panel believes that immediate opportunities abound to spread the word about mandated reporter training and increase its effectiveness. Working with relevant academic departments within higher education institutions in the state of California could result in mandated reporters receiving high quality training as part of their educational program if they are pursuing a field that requires them to report suspected maltreatment. Sending new professionals into the field with an awareness of mandated reporter laws will most certainly have a positive effect on reporting.

Recommendations

The Critical Incident Citizen Review Panel recommends that:

1. CDSS work with county child welfare agencies to train mandated reporters not only to recognize suspected child abuse and neglect but also to understand how to make a report that will rise to the level of a child protective services investigation, if appropriate.

2. CDSS work with institutions of higher education to include mandated reporter training in curricula for students entering a field in which they will become mandated reporters (i.e. medical schools, law schools, social work programs, public health programs, corrections and law enforcement programs, teaching programs, nursing programs, and others).

3. CDSS work with the State Dept of Education to ensure that all employees who are mandated reporters are trained uniformly with minimum standards (e.g. eight-minute videos to meet this mandate should not be allowed).

Local and State Child Death Review

As the Panel progressed in their work, conversations turned to the fact that the state does not know how many child abuse and neglect fatalities and near fatalities, in which child abuse or neglect was a material cause, occur each year. California's statewide child death review team, previously housed in the Department of Justice, was disbanded due to a lack of funding.

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CDSS' Critical Incident Oversight Unit (CIOU) reviews fatalities that are reported to them but the fact that only certain professionals are able to designate a case as a fatality may cause lower numbers to be reported. Only the coroner, local law enforcement, or child welfare can designate a case as a fatality and even within these professions, there is no consistency of designation within a county. Local child death review teams do not have the authority to designate a case as a fatality in which child abuse and neglect is a material cause. Local child death review teams' reports are also not sent to the CIOU.

California law currently requires the coroner, law enforcement, and child welfare to cross-report, but panel members report that the mandate has been "suspended" also due to lack of funding. The state has no way of knowing whether all the fatalities are being reported and included in the state data sets. Without accurate data, it is impossible to get a complete picture of child abuse and neglect fatalities in the state, identify trends, or utilize information

to prevent further fatalities. In addition, due to insufficient critical incident data collection and reporting infrastructures in California, there is a lack of understanding of the full scope of the issue, which results in a lack of confidence in the ability to convey to policy-makers and the public the seriousness of the issue.

The Panel met by phone with Steve Wirtz, PhD, Chief, California Department of Public Health Injury Surveillance & Epidemiology Section. Dr. Wirtz has extensive experience in child death fatality and near- fatality review and is the State Coordinator for the Fatal Child Abuse and Neglect Surveillance program. He spoke to the panel about both the state and local child death review teams.

Without accurate data, it is impossible to get a complete picture of child abuse and neglect fatalities in the state

Dr. Wirtz shared with the group that local child death review teams are a vital tool to address child abuse and neglect fatalities in a multi-disciplinary way. Local teams should be conduits of information to a state team. All counties in California do not have local child death review teams. In those counties that do, local teams do not all utilize the same process to review fatalities and near fatalities, nor do they report data consistently to the state. There is funding to support local teams, but it is unclear how that funding is distributed.

Dr. Wirtz suggested the state team be reconstituted, empaneled, and empowered by multiple state entities, not one agency alone for its own purposes. The call to reconstitute the state team should come from multiple agencies acting together to define the team's purpose and source of funding. The state team itself should be a multi-agency/entity to maximize their collective impact. The state team should be focused on how to improve the functioning and standardization of local teams as conduits to the state team so they can collect and act upon issues expeditiously.

The Panel believes that there is no more important issue to prioritize and to remedy in the child welfare system than child abuse and neglect fatalities and near fatalities. The importance of the panels' learning from the review of child abuse and neglect fatalities and near fatalities and using the information to prevent future deaths cannot be overemphasized. The panel believes it is time for the State of California to recommit to the importance and sustenance of a state team and well-functioning local teams.

Recommendations

The Panel acknowledges that the recommendations they are delivering go beyond the ability of CDSS alone to implement. Because child fatalities and near fatalities are a tragedy in the state, the Panel believes it is important to illuminate all their concerns about state and local policies and processes. The Panel requests that CDSS share these recommendations with involved entities once they are finalized and encourage their adoption.

The Critical Incidents and Child Fatalities Citizen Review Panel recommends that:

CDSS work with the Department of Public Health, the Department of Justice, and local child death review teams (hereinafter "the partners") to improve the process, data collection, and reporting of child abuse and neglect fatalities and near fatalities, to prevent them in the future, by implementing the following:

At the state level

● Reconstitute and sustain a State Child Death Review Team with a clear charter and purpose to connect with local child death review teams to ensure consistent practice, analyze trends, and take bold action to end child fatalities and near fatalities in California.

● "The partners" work together to develop consistent evidence-informed criteria for local child death review teams to follow so all child death review teams utilize a standard protocol and information is consistently reported to the state.

improve the process, data collection, and reporting of child abuse and neglect fatalities and near fatalities

● CDSS review and consider information from the National Center for Fatality Review and Prevention, information from other states, and information from exemplary California county child death review teams to learn what has been studied and what has been effective in fatality review to provide guidance to the partners in developing evidence informed practices.

● CDSS report the actual number of fatalities that occur in a calendar year rather than the number of reports they receive to get clearer longitudinal data.

● "The partners" work together to develop and pilot consistent criteria for designating a case as a fatality or near fatality and reporting of same by law enforcement, child welfare, and the coroner's office. Clear definitions about child abuse/neglect as a material cause and

consistent reporting are necessary to understand the patterns across the state.

● Local child death review teams be designated as determiners of whether abuse or neglect was a material cause for a fatality or near fatality.

● CDSS review the reports of the local child death review team when they are reviewing fatalities. CDSS aggregate the findings of the local review teams so that more accurate numbers and trends can be established.

● "The partners" work together to review child death review practice in other states and adopt a consistent and effective model.

● The state recommits to the responsibility of child welfare, the coroner's office, and law enforcement to cross report fatalities and near fatalities. The Panel recommends the partners conduct an assessment of the actual cost to make this happen and reallocate such funding.

At the local level

● All counties empanel local child death review teams, pursuant to California Penal Code 11174.32 et seq, that operate in a consistent manner and report data consistently to the state.

● Counties require cross reporting among law enforcement, child welfare, and the coroner's office to ensure all fatalities and near fatalities are so designated.

● Local teams provide their findings to CDSS and CDSS consider those findings when conducting a child death review.

All counties empanel local child death review teams, pursuant to California Penal Code 11174.32 et seq, that operate in a consistent manner and report data consistently to the state

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Appendix I: Public Comment

Public comment was collected via a web-based survey portal. A link to the portal was shared broadly by OCAP and by panel members. Two versions of the portal were established and shared: one in English and one in Spanish. The portals were open for one week, from September 14 to September 21.

Overall, public comment was made by 74 people. Comments were made on the Prevention Panel recommendations by 60 people. Comments were made on the CFS Panel recommendations by 55 people. Comments were made on the Critical Incidents Panel by 57 people. Seventy-three of the overall respondents made comments through the English language portal and one person made comments through the Spanish language portal.

Summaries of the public comment with highlighted themes are presented below for each panel.

Prevention Panel

Overall, many of the respondent made comments indicating that they were in agreement with the Panel's recommendations. For example, one person said, "I agree with the recommendations of the Panel re: FRCs." Another said, "These recommendations are perfect. Taking these steps is long overdue. Collaboration with FRCs is absolutely vital."

Overall, many of the respondent made comments indicating that they were in agreement with the Panel's recommendations

Aside from many comments that expressed agreement with and support of the Panel's recommendations, there was a theme of general support for FRCs. For example, one person said, "FRC's are a strong partner in the delivery of prevention services." And another said, "Family Resource Centers pay a critical role in the community, they are well positioned to ensure all families have access." Similarly, another said, "Los FRC son el punto de partida para continuar promoviendo el fortalecimiento de las familias y comunidades (FRCs are the starting point for continuing to promote the strengthening of families and communities)." Throughout the comments, support for FRCs was a strong theme.

There were also several comments about ensuring that FRCs are adequately funded and ensuring that CDSS support FRCs. One person commented that, "FRCs must be financially supported to conduct outreach beyond what they currently do." Another commented that, "It is important that the CDSS engages and ask

FRCs what supports they need." One comment further suggested that, "Ensuring FRCs as [a] priority network needs to be combined with a financial commitment to ensure ongoing support." And another said, "CDSS and all FRCs should work closely together."

Another theme brought up engagement of community and of parents in particular. One comment was, "Engaging community and supporting structures certainly strength[en]s the fabric of child welfare systems." Another commented, "Please include family, friends and neighbors in the scope of work." One person commented that FRCs "are so successful in their delivery is because of their use of Parent Leaders and by serving the communities with community members." Comments highlighted the idea that FRCs support the involvement of parent partners and mentors and involve friends, families, and communities in their work.

There were a number of comments about challenges facing the utilization of FRCs in this work. Training of FRC staff came up in more than one comment. One person said, "FRC lay staff need appropriate training in intervening with families." Similarly, another said, "there should be a standard established for FRC staff education level and training." Another said more generally, "Concern whether the FRCs are adequately equipped to execute on these objectives." Several others commented on the diverse nature of FRCs and a lack of consistency, services, structures, and quality across FRCs. A few made comments about not understanding what FRCs were or not knowing about FRCs in their own communities.

"Engaging community and supporting structures certainly strength[en]s the fabric of child welfare systems."

Finally, there was one comment about eligibility for FRC services. One person was concerned that FRCs base service eligibility on foster parent income. The person suggested that all families fostering children should be able to access FRC services.

Child and Family Services Panel

Overall, there was wide support for the Panel's recommendations. Many respondents said things like, "Agree," "Good recommendations," and "I support the recommendations." These direct statements of support and agreement were common across all the comments.

There were a number of comments, however, that expressed concerns about the recommendations. One person commented that efforts to establish best practices for visitation might be "noble," but the real problem was that judges too often defaulted to

reunification in case plans. That person expressed their opinion that visitation was too "lenient" and was exposing children to further harm. Another person expressed that they had the "opposite problem," and that child welfare spent too much time trying to work with the parents. Another expressed their concern by saying, "This is flawed entirely, it assumes our current policy of family reunification is working - it is not. DCFS offices are applying to liberal visitation policies that are endangering children and a study should be done where Judges reverse home visitation due to higher child welfare risks or failed family reunification. In instances where reunification is warranted supervised visitation has been key. Unsupervised visitation is not fair to the child and ordering 7x a week visitation makes no sense, don't take the child away."

"Unsupervised visitation is not fair to the child"

Others highlighted the need for and challenge of establishing evidence-based best practices. One person said, "Best practices would be helpful for counties to strive for." Another said, "collaboration and the use of best practices are great tools to leverage for this project." One person commented that best practice [guidelines] must be based on "models that have demonstrated strong positive outcomes for children and families." Another commented, "All efforts to improve visitation should be based on what has made a difference in other jurisdictions, including territories and states, for visitation programs that increase key outcomes such as placement stability, safe reunification without re-entry, wellbeing and timely permanency." And another said, "Recommend looking beyond other states and reviewing best practice developed worldwide." At the same time, others warned that, "Statewide mandates are a slippery slope. ACLs from CDSS are frequently poorly conceived and appear to be written by people who have had little field experience in many years. California is a diverse state and a one-size-fits-all mandate is ill-conceived. Determination of practice should remain with each county in a plan submitted to the state." Public comment included the fact that some agencies have written protocols which should be examined by the Task Force, along with other state and national level resources, to draw from the best California has to offer.

Other comments focused on things like who should be involved in determining visitation plans, like foster children and probation workers. Several people commented on the logistics of visitation planning, including distance, where children were placed, and transportation. Several people commented on how they work with partners to accommodate

visitation, including visitation supervision and locations for visitation. And one person commented that, "There is some discussion from moms/ dads about the word 'visitation' and the message, looking for more current, progressive language that promotes the relationship and bonding."

Critical Incidents Panel

Many people commented that they agree with the Panel's recommendations. Comments included things like, "Agreed," "Support," "Highly agree with this recommendation," "I agree," and "Good Recommendations!"

Comments included things like, "Agreed," "Support," "Highly agree with this recommendation," "I agree," and "Good Recommendations!"

Many people commented on what was needed for training. One person said, "Any provider or organization that interacts or serves children in any capacity should be required to complete full mandated reporter training annually." Similarly, one person stated that, "training should also be repeated periodically to refresh knowledge." And another said, "Licensed mandated reporters should be required to go through training on a regular basis."

Another commented that training should include, "awareness of Differential Response and CSEC (commercial sexual exploitation of children)." One person commented, "I would suggest you also address training to those who deal with the homeless population." One

"Any provider or organization that interacts or serves children in any capacity should be required to complete full mandated reporter training annually."

person commented that training should focus on completing the form, "The bottom line is teaching mandated reporters how to fill out the form correctly and the fact that the mandated reporter is NOT responsible for investigating the possibility of abuse, CPS is."

Others commented on the delivery of training. One person said, "The state should require a face to face mandated reporter training and not rely solely on an [online] training." Another said, "Online videos for MRTs are not sufficient." And another commented, "Mandated Reporter Trainings need to be in person." In contrast, another said, "I would love to see [a] full [course] offered online for employees and new employees to access immediately upon employment."

A few people commented about the usefulness of a printed guide for mandated reporters. One person said, "A printed guideline given to mandated reporters to guide them in who to talk to and what needs to be reported would be

quite helpful." Another said, "Our County is currently working on creating a guide for Mandatory Reporting. I am hopeful that it will be a help."

There were a number of other issues brought up by a single person. One person said, "I believe there should be a state-wide agency whose only job is to report, investigate, and act on child fatalities and near fatal incidents." Another commented that, "Child Death Teams need to have immunity from subpoena and be free to review "open" cases." Another suggested, "Ensure no childcare workers are ever prosecuted and are exempt for civil suits for reporting suspected abuse." One person said, "I think if something is brought to your attention that the person reporting stay anonymous." One said, "The process to submit reports should be less onerous." One said, "Too many mandates come to the state, passed down to the county agencies that demand new action but without the funding to make it happen." One person said, "including in the mandated reporter training language that speaks to some of the cultural traditions of various individuals not just typical 'American' norms." Another person lifted up the issue of marijuana legalization and mandated reporting in that both parents and mandated reporters should be trained on the effects of marijuana during pregnancy.

There were some doubts about the recommendations. One person said, "This recommendation while noble will not prevent deaths, just gather data and gruesome details - waste of precious resources." Another person said, "Training is the low hanging fruit, and a waste of federal/state resources. Mandated professionals commit to a code of ethics, training is part of their education and certification. These efforts will not affect desired improvements."

"This recommendation while noble will not prevent deaths, just gather data and gruesome details"

Appendix 2: Panel Members

Prevention of Child Abuse and Neglect Citizen Review Panel Members

Barbara Besana, Kids First, Placer county

Alex Morales, Child Welfare League of America, Chair, Board of Directors

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Lisa Morrell Korb, Program Officer, Family Support Initiative

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Marni Parsons, Vice President of Student and Family Services, Bright Star Schools, County of Los Angeles

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David M. Dunning, Social Worker IV, Child Protective Services, El Dorado County

Jessica Payne, CEO and Director of Research, Mockingbird Analytics, Los Angeles County

Sheryn Hildebrand, Executive Director, CASA of Mendocino and Lake Counties

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Appendix II: Big Picture Research and Consulting Project Team

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Nancy Miller, Consultant

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Parissa Tadrissi, PhD, Consultant

For more information on BPRAC, visit www.BPRAC.com

Appendix III: Prevention of Child Abuse and Neglect CRP Materials

Reports and Materials Considered by the Prevention CRP

- OCAP FRC List
- Prevention Partner Survey Report
- Vehicles for Change, Volume I
- Vehicles for Change, Volume II
- Standards of Quality for Family Strengthening and Support
- The Costs for California, The Child Abuse Prevention Center
- AmeriCorps Impact Evaluation - Birth and Beyond Home Visitation (FRC Initiative)
- Capacity Building - Creating and Sustaining Cross-System Collaboration to Support Families is Child Welfare with Co-occurring Issues: An Administrators Handbook
- The Economics of Child Abuse - 2018 Study of Napa County
- Child Abuse Prevention Center Continuum of Services Model
- Child Abuse Prevention Center Overview 2016

Appendix IV: Children and Family Services CRP Materials

Reports and Materials Considered by the CFS CRP

● Federal: 52 Program Improvement Plans Strategies for Improving Child Welfare Services and Outcomes, US Department of Health and Human Services

● State of Georgia: Family Time/Visitation: The Road to Safe Reunification

● State of Minnesota: Child and Family Visitation: A Practice Guide to Support Lasting Reunification and Preserving Family Connections for Children in Foster Care

● State of Vermont: Department for Children and Families, Family Services Division, Initial Caregivers Meeting, Shared Parenting Meetings and Family Time

● Compilation of California statutes related to visitation, case plans, and related topics.

● Child and Family Services Plan 2015-2019, California Annual Progress and Services Report, June 30, 2016

● California Round Three Federal Child and Family Services Review Results

● Los Angeles Superior Court, Juvenile Court Visitation Committee, Family Visitation Guidelines, Juvenile Dependency Court Protocol for Developing Family Visitation Plans, 2005

● Los Angeles County Proposal to Chapin Hall: Strategies to Improve the Efficiency of Parent-Child Visitation, October 2017: Logistical Challenge of Arranging Visits between Children and their Families Cries for Technological Solution

● San Diego County Department of Child Welfare Services, NCCD Literature Review, To Improve Visitation Practices, 2017

● Office of Child Abuse Prevention, Visitation Data

● Interview Themes Memo

Appendix V: Critical Incidents CRP Materials

Reports and Materials Considered by the CI CRP

● Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study

● Best Practices or Mandated Reporters

● CDRT Survey

● National CFRP Child Death Review Case Reporting System - Case Report - Version 4.1

● Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities

● Sacramento County: Child Death Review Team and Fetal Infant Mortality Review

● SCIP Best Practices for Mandated Reporters

● Preventing and Reporting Child Abuse and Neglect: Guidance for School Personnel

● Associate Commissioner's Vision for the Children's Bureau

● California's Mandatory Reporter Training for Child Care Workers