2014 - 2015 Citizen Review Team Report

Background

There are twelve Citizen Review Teams as established by the Texas Family Code (TFC §261.312). Five of these teams are designated as meeting the requirements of Child Abuse Prevention and Treatment Act, Appendix I. This report consists of information concerning the issues addressed only by the five Child Abuse Prevention and Treatment Act (CAPTA) teams. They are located in Amarillo (Region 1), Austin, (Region 7), Edinburg (Region 11), Ft. Worth (Region 3), and Houston (Region 6). The Houston team focuses on issues concerning disproportionality. These sites represent a mixture of urban and rural communities, and reflect the broad range of issues encountered by Child Protective Services statewide.

Structure

As required, all Citizen Review Team members, including those of the CAPTA Citizen Review Teams, are volunteers who represent a broad spectrum of their communities. The members are nominated locally and approved by the DFPS Commissioner. CPS state office staff provide assistance in the areas of coordination, team development, training and statewide distribution of team reviews and recommendations. Local CPS staff facilitate the exchange of case-specific information, ensure that confidentiality is maintained, perform the required background checks on nominated members, and arrange for meeting space and clerical support.

Reporting Process

To coincide with the federal fiscal year reporting period, this report covers the period from October 2014 through September 2015. Information presented consists of data gathered by the CAPTA Citizens Review Teams. The teams utilize the Citizen Review Team Reporting form, a standardized form that was developed by CPS state office for the teams and modified in December 2012. .

Agency Response

Citizen Review Team recommendations are placed on the DFPS Web site after approval of each Annual Program and Services Report. In addition to the recommendations from the Child Abuse Prevention and Treatment Act (CAPTA) teams, it is anticipated that the recommendations and concerns expressed by other, non-CAPTA teams will be published on the website in the next fiscal year. The Web page for recommendations contains a Citizen Review Team specific mailbox that the public can use to comment on the recommendations. That Web page is: http://www.dfps.state.tx.us/Child_Protection/CRT/.

State office program staff review Citizen Review Team recommendations and those recommendations are considered in policy development, training and procedures. The CAPTA teams often present recommendations for local CPS direct delivery staff about actions they would like to see taken on a particular case. These case-specific recommendations are communicated during the Citizen Review Team meetings to the CPS representatives who are present, and are recorded on the standardized reporting form. Actions on case-specific recommendations are handled at the regional level.

Panel Activities

In August 2012, a consultant with the National Resource Center for Child Protective Services met with fourteen coordinators of Texas Citizen Review Teams. Two of the coordinators are currently in the process of rebuilding their teams. Their teams have not been active and were not counted in the total number of teams. The group discussed the history of the Citizen Review Teams and also the findings from a survey of the Citizen Review Team members, completed by the resource center. During initial consultations and the onsite visit, one of the most significant challenges identified was that although CPS was providing the Citizen Review Teams individual, anecdotal case data, teams were being asked to make broad, systemic recommendations. Each of the teams was identifying cases at random and therefore the sample size for the anecdotal reviews was extremely small. Given the size and diversity of Texas, the teams did not have enough information to determine systemic issues and/or develop effective recommendations. As such, the department was having a difficult time responding to or implementing many of the recommendations, as they were based on limited data, often limited to a specific case and not supported by systemic data, not specific, or generally not actionable.

During the site visit, a new process was developed in order to enhance the Texas Citizen Review Teams. More specifically, technical assistance from the resource center assisted the participants in determining that a better process would be to identify a critical systemic issue that all teams would focus on and that CPS state office personnel would provide data beyond case data. This would provide teams with a wide range of data from which to build their recommendations.

For fiscal year 2015 the Citizen Review Teams continued their focus on child welfare cases that involve domestic violence and improvement policy, practice and outcomes for such cases. Teams are being provided state and regional quantitative data comparing domestic violence cases that had reentry from those that did not in order to identify trends by age, ethnicity, income, and other variables. Teams are provided current domestic violence policies and will be assisting in the development of new domestic violence policies.

The coordinators are CPS staff assigned to this project. As a result of staff turnover and change in staff at the state office some of the teams have not been as active as in previous years.
The Citizen Review Team coordinators work to establish local and statewide strategic planning, frequent and regular meetings of active teams, and formation of new teams. The Citizen Review Team coordinators meet regularly with state office program staff to discuss better ways to engage the community in the review process. A Citizen Review Team coordinator's manual has been developed and is available as a resource for each team.

The five CAPTA Citizen Review Teams met as follows from October 2013 through September 2014:

- Region 1 (Amarillo/Potter County): no meeting datesRegion 3 (Fort Worth/Tarrant County): July 1, 2015, September 8, 2015
- Region 6 (Houston/Disproportionality): This team meets monthly. Region 07 (Austin/Travis County): no meeting dates
- Region 11 (Edinburg/Hidalgo County): February 25, 2015, March 25, 2015, April 22, 2015, August 23, 2015, September 15, 2015

The CAPTA Citizens Review Team coordinators continue to work with their communities to engage and encourage volunteers to become involved in efforts to gain feedback from the public.

Summary of Findings

CPS Protection Initiatives

The following chart describes issues and concerns that relate to the CAPTA Citizen Review Team identified issues. These CRT reports were presented to the Child Safety Review Committee inthroughout the year. The CRT recommendations and the CPS response will be posted on the public website. Other recommendations made by the teams were case specific and referred to regional management.

Region/ Date	Issue Addressed	Recommendation
Region 3 CAPTA	The team reviewed the Investigation and FBSS stages of one case involving domestic violence, possible alcoholism and where the family did not speak English.	• CPS needs more Spanish-speaking caseworkers. • This case reflected a need for training on family violence in both stages of services reviewed. • When some says they drink heavily, do more to determine what is heavily…..ask more questions or talk to collaterals to assess how often they are drinking. • When a caregiver admits to history of drug use, random drug testing should be conducted. • The caseworker should identify the strengths within the family and build on them. The mother had many strengths that were never identified. • Ask the family what they would like to see happen. They may be able to determine what services they need and what the underlying issues are. Involve the family in creating of the services and planning. • When there are concerns such as substance abuse, get the parents to participate in the drug /alcohol assessment sooner than later. It is best to get the assessment early in the case. • Do more to engage caregivers. Home visits could have been at hours convenient for the father and with a translator. • If the intent of the caregiver is to be together and they have started services, the Department should work with the family residing together in the same home. • CPS should not be involved with families longer than necessary. Even after the father was deported, CPS was still involved with the family. • The non-offending caregiver and victim in the situation had to do more services than the offending parent. We should not punish both parents in a family violence situation. The caregiver that was protective and appeared to have acted appropriately was also the victim of the domestic violence. She was also the caregiver appeared to have been asked to do the most services and received the most attention from the caseworker. • When a family verbalizes or indicates they want to be together, services should be geared towards addressing the family violence and helping the family reunite. The family wanted to resolve their issues and wanted to reunite the family. Couples counseling or family counseling would have been beneficial.
Region 3 CAPTA	The team reviewed the Investigation and Family-Based Safety Services stages in a case. They noted that during the investigation, the child was not seen timely and the parents were not notified in a timely manner of the child's interview. Also,	• CPS Investigation staff should contact the police department to determine if there have been any prior calls or involvement with the family. • Additional efforts should be made to have the father participate in services. If a parent reports that their work schedule is an issue, staff should seek alternative services that will work with his/her schedule. • All efforts should be exhausted to locate fathers. • For the FBSS staff the team recommended that: • When there are issues of family violence, the children should be offed counseling • The school should be contacted periodically to check the children's progress

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	reasonable efforts were not made or documented to locate a parent. They thought that additional collateral calls were needed to determine if there was family violence or other concerns in the home. The team had concerns that during the FBSS staff there were no unannounced visits and they were concerned that the children were never interviewed alone.	and any concerns. • There should be unannounced visits to the home. • More follow-up is need with the school/counselor, particularly when the school/counselor has mentioned concerns. • Parents should participate in services that address drug use when that is an issue. • In family violence cases, services should be tailored to address family violence, such as referrals to the local family violence program, BIPP, or other services that address family violence. • Hold all parties responsible for participating in services, including paramours. • All efforts should be exhausted to locate fathers. • All Caseworkers need training on family violence, getting paramours to cooperate and the effects of family violence on children.
4	The team reviewed the Intake and Investigations stage of one case involving domestic violence and substance abuse.	• A lack of services in our rural areas creates a big gap in being able to make referrals. In the case the disposition was ruled out, but the family could benefit from some services. Transportation and time is always a big factor.
5	The Investigation, FBSS and Substitute Care stages of one case involving family violence and substance abuse.	• The team noted that there was an issue with the children's mother not being able to visit the children in their relative placement. Due to felony drug charges the mother was not allowed to be in a licensed placement. Therefore she could not visit in the relative placement if the relative chose to meet DFPS licensing minimum standards. The relative decided not to meet minimum standards so that the mother could visit her children in the home. One of the consequences of this is that the relative was not eligible for fostering connections benefits. • The team recommended an exception for parents facing felony charges to be able to visit their children at home when the children are with grandparents.
9	The Intake and Investigations stages of a case involving domestic violence were reviewed.	• The team identified the need for a batterer's intervention program in the area that contracts with DFPS. • The team discussed the issue of dealing with domestic violence cases and asking the adult victim to leave home with the children, but getting no assistance with housing. It was recommended the Department find resources to assist adult victims with housing when possible.
11 CAPTA	Team reviewed the Intake, Investigation, FBSS stages of two cases. All policies were followed. The lack of available, quality service providers was an issue.	The team noted a need for more service providers available for families receiving Family Based Safety Services (FBSS).
11 CAPTA	The team reviewed the Intake and Investigation stages of a case. In the Intake stage all policies were followed. In the Investigation stage employee turnover was an issue, leading to the case being open in Investigation too long.	A better procedure needs to be in place to ensure that when a worker leaves, their cases are still being worked in a timely manner.
11 CAPTA	The team reviewed the Intake, Investigation,	CPS staff needs to make referrals to the local domestic violence program. After the CRT meeting an email was sent out to program directors in the region asking

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	FBSS stages of a case. It was noted that all policies were followed in all stages, but there was a lack of collaboration with the local domestic violence program.	them to remind supervisors and staff about making a referral in all cases of domestic violence.
11 CAPTA	The team reviewed the Intake and Investigation stages of a case where lack of documentation in Investigation was an issue. Additionally, there appeared to be gang involvement in this case and the need for assistance from law enforcement was highlighted.	Better documentation in a case so that all of the information is in the record. Better monitoring by supervisors when they are reading cases to help ensure complete documentation.
11 CAPTA	The Intake, Investigation and FBSS stages of a case were reviewed. The team felt that policies were followed, but that more complete information would have been helpful in addressing the child's needs.	Need for more complete information about a parent's criminal history and better use of this information when making case decisions. The need to get more complete information in order to determine the needs of the child.
11 CAPTA	The team reviewed the Intake, Investigations and FBSS stages of a case where domestic violence had occurred.	• A need for more training and skill development on interviewing and information gathering was noted for both Investigation and FBSS stages of services. This would help staff better identify issues in serving the family. • Engage fathers in all cases.
11 CAPTA	The team reviewed the Intake, Investigations and FBSS stages of two cases involving co-occurring domestic violence and child abuse, including a case where one parent committed suicide.	• Preponderance of the evidence should be outlined and stated in support of the documentation for the reader to see and understand. Recommendation made to have a section in the investigation where preponderance of the evidence is clearly established and documented in support of the case disposition. • Workers and supervisors should be expected to spell-check their documentation before the case is approved. Cases at times become legal cases and words and names of clients are often misspelled or incorrectly documented which can have detrimental effects on the legal case. • In one of the cases reviewed, a parent committed suicide; however there is no documentation which indicated that any of the services offered to the family included services to the child(ren) specifically regarding the suicide, loss issues, grief counseling, etc… • Intake report indicates or asks about "Suspected Manufacturing of Methamphetamines"; however, there is no prompting for other types of drugs such as marijuana, cocaine, or drugs in general. The front page of the Intake report should also reflect "Suspicion of drug use" in general. • Efforts to establish support system in all cases where there are allegations of Domestic Violence including threats to life. • There is often a repeat to the cycle of abuse as parents often allow the Domestic Violence to continue by allowing the Perpetrator to remain or return to the home without receiving any services. Laws need to be strengthened to ensure that services have been received by the Perpetrator as well as the

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		victim(s) of Domestic Violence including the children. This includes services offered by CPS which should include all victims, including children and the Perpetrator. • In review of the FBSS cases, ages of the children are incorrect throughout the life of the case and this is confusing. Ages, and person detail information need to be correct. • The length of time of cases should be consistent with the goals and compliance by each of the family members. Obstacles encountered in each case should also be carefully assessed and evaluated to determine additional tasks, services, or possible legal action, if necessary. • Each case is unique and case actions and services should have specific services to address those needs. • Each case should have appropriate and relevant collaterals whether investigation, FBSS case or CVS case and not just individuals who have no relevant case information.
11 Cameron	The Intake, Investigations and FBSS stages of two cases involving domestic violence were reviewed. In one case substance abuse was also an issue for one adult family member.	• In one of the cases reviewed, Client had self-enrolled and had already attended 6 Substance Abuse sessions before being referred to FBSS. Client already knew what was going to be requested and there is a question as to if the client was just attending classes as she already knew what to expect or because she wanted to completed the classes and have her case closed. This is suggestive that the clients are perhaps not attending classes to change but rather just to have their CPS cases closed faster. • It was recommended that substance abuse cases be thoroughly assessed and that caseworkers understand the need to find appropriate and proper treatment for these clients in order to bring about the changes needed to ensure child safety. • Workers need to contact Law Enforcement Investigators assigned to Domestic Violence cases to ensure that Emergency Protective Orders are being provided to the victims of Domestic Violence cases. CPS workers need to be persistent in speaking with the Law Enforcement Investigator/Detective or speak to the Supervisor in order to ensure that the Emergency Protective Order is requested or given to the victims. • CPS workers need to ensure that the children are also being included in the Emergency Protective Orders as well as the 2 year protective orders. • Children exposed to Domestic Violence are victims of **Violent Childhood Experiences** and must be provided with protection by Law Enforcement, Court System and CPS. • In CPS cases where Domestic/Family Violence has been identified, District Attorney staff, working with CPS, have agreed to file Protective Orders at the time of investigation. • CAC Interviews not being done timely and law enforcement should take an active role in these interviews. These interviews should be done expeditiously by CPS Staff even if Law Enforcement is not moving on these cases. • If a parent is not being protective and not willing to file for a Protective Order, then CPS should be able to file for a Protective Order on the children's behalf. • Medicaid should notify Vital Statistics if a child is born while CPS is working with the family. In other words, it is recommended that a system be in place in which upon the birth of a child and it is determined that CPS is involved that agencies such as Vital Statistics and Medicaid flag the case and communicate with CPS to ensure that CPS is aware of a new birth. • In some child death cases, Statewide Intake is not accepting reports even when there is some suspicion of Abuse or Neglect. This is frustrating as the Medical Examiner and other medical personal is unable to make reports as SWI will not accept the calls. SWI is telling reporters that the case is "unreportable". These are professional reports such as medical staff, medical examiner, etc… • New form of Child Abuse is identified due to child's environment and violent

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		childhood experiences which needs to be included in order to make a difference in families where Domestic Violence is being experienced. • CRT Member has formed a support group in her church called WINGS (Women In Need Growing Stronger). This is a 12 week session support and educational group to address adverse childhood experiences. This is a project of Blue Sunday.
11 CAPTA	The Intake and Investigations stages of two cases were reviewed.	• More information was needed and more probing with the family in order to better assess the allegations made. • More collateral contacts were needed in the case to fully assess how the family was truly functioning. • It was recommended that one family be referred for services to address Domestic Violence issues even though they had been referred in the past.
11 Cameron	The Intake and Investigations stages of two cases involving domestic violence were reviewed, including one case where the family moved and was unable to be located.	• Inquiry was made as to what efforts were/are made when a family moves and cannot be located. • It was recommended that schools be contact in order to track down families who move, leave the area and cannot be located otherwise. • Comment made that local District Attorney's Office staff is wanting to use Executive Director of Family Violence facility and staff to serve as an expert witness for the purpose of educating a Jury Panel in DV cases when there is a request for charges to be dropped; however, the client of the shelter, who is also present in the court room may feel threatened by this action and therefore not seek services in the future. • Cases in which there is past Domestic Violence and Drug allegations need to be assessed further to ensure there are no current issues or drug related issues.
11 CAPTA	The Intake, Investigations and FBSS stages of two cases involving family violence were reviewed.	• It was recommended that there be more communication between CPS and Domestic Violence Facilities. In this case, one parent was the aggressor yet went to the Family Violence Shelter and claiming to be the victim. In so doing, the shelter initiated services and contacted the school to have the children withdrawn from their school and was taken to the shelter. CPS attempted to contact adult at the shelter in an effort to initiate the investigation, see the children etc., however they were unable to do so due to the confidentially as well as adult not wanting to work with CPS. • It was commented that more men are coming forward more and more and need to be able to have access to the same type of services and protection as women have. In this particular case the adult victim of Domestic Violence and was not offered services through either CPS or the Family Violence Shelter. • It was recommended that more questions be asked during the course of the investigation and service to the family in order to know more about the abuse and the effects it has on the children and the entire family. • It was highly recommended that cross training be held between the two agencies being CPS as well as Family Violence Shelters in order to understand each other's process and procedures and to have better communication between the two to service families together. • It was recommended that when a family is referred to services in the community such as counseling, drug/alcohol services, etc., that these be verified with the service provider actual successful completion such as the clients truly making life changes not just attending classes. • In one of the cases reviewed, family counseling did not include the Father and this was a critical issue since there needs to be a safe place in which to hold family members accountable for the violence. • In one of the cases reviewed, there was no contact between the father and the family during the course of the entire FBSS case until the end of the case when father moved back into the home without CPS permission and the case was closed despite him not completing services recommended. • Family was sent to receive counseling services through an agency called

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		"Angels of Love" and there were several comments that although the services were free, this agency was "questionable".
11 Cameron	The Intake and Investigations stages of two cases involving domestic violence were reviewed, including one case where there was also illegal drug activity. .	• A question was asked about the outcry made by the reporter/victim and why the case was ruled out despite consistent and believable information made by this person. Response was given that although the information provided on the report and confirmed by other children in the home, the discipline did not rise to the level of abuse. • A question was made as to the current status of the OV/reporter since he was incarcerated and also mention was made of effects of Negative Childhood experiences and the role of these experiences in being a predetermined factor for incarceration and disease. In this particular case the OV was a victim of abuse by his own father and step-father and was now incarcerated. • A question was asked about whether or not cases involving drug activity allegations are worked together with law enforcement? Specifically execute a search warrant or send a drug sniffing canine unit into the home. An explanation was made that not all the drug related cases reported to CPS are worked jointly with law enforcement and that cases in which there is a strong suspicion of drug use would be reported to local law enforcement units. • A question was asked regarding the validity of drug testing on clients. An explanation was provided to the CRT members regarding the various drugs testing available to staff and the effectiveness of these tests to determine on-going drug use.
Region 11 CAPTA	The team reviewed a case involving domestic violence and noted that there were several red flags evident in the case.	• CPS should have ensure that a family member obtain guardianship for the children in order to protect from further abuse. • A protective order could have been/should have been filed by CPS for the children to protect them from should the offending parent return to the country illegally, as had happened in the past. • There was an issue with the AP/Parent being arrested by law enforcement for family violence and turned over to ICE. The investigation worker assumed the AP had been deported, although this was not the case. The AP was in custody pending the case being set before a judge. Therefore, there was time to file for an emergency protective order since the AP could have been served. • Case was closed with a Reason to Believe - Factors Controlled. The team felt the factors were not controlled in the AP would probably return to the country and continue to place the children at risk. • The team recommended that CPS staff receive training by the DA's office include issue such as protective order, ICE detention, service of protective orders to individuals in jail, and other related issues. • The team cited a need for a national data base to track if parents have had CPS history in other states, as was the case in this situation.
Region 11 CAPTA	The team reviewed a case involving domestic violence and noted that there were several red flags evident in the case.	• CPS should have ensure that a family member obtain guardianship for the children in order to protect from further abuse. • A protective order could have been/should have been filed by CPS for the children to protect them from should the offending parent return to the country illegally, as had happened in the past. • There was an issue with the AP/Parent being arrested by law enforcement for family violence and turned over to ICE. The investigation worker assumed the AP had been deported, although this was not the case. The AP was in custody pending the case being set before a judge. Therefore, there was time to file for an emergency protective order since the AP could have been served. • Case was closed with a Reason to Believe - Factors Controlled. The team felt the factors were not controlled in the AP would probably return to the country and continue to place the children at risk. • The team recommended that CPS staff receive training by the DA's office include issue such as protective order, ICE detention, service of protective

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		orders to individuals in jail, and other related issues. • The team cited a need for a national data base to track if parents have had CPS history in other states, as was the case in this situation.
Reg 11 CAPTA	The team reviewed a case where insufficient information and employee turn-over hampered the case. They team noted that time frames were not met for completing the investigation. Also, information from the hospital that the investigator didn't obtain would have changed the decisions made in the case.	• Workers need to know how to do a thorough, non-incident driven investigation. Additionally, CPS needs to look at the effects of the abuse/neglect on the victims and provide services accordingly. Often the agency looks at how to fix the parents and ignores the victims.
Region 11 CAPTA	The team reviewed a case that had gone through the Administrative Review process. The Administrative Review upheld the disposition in this case which was seen as positive by the team.	
Region 11	The team reviewed a case where they thought the case disposition did not reflect all of the issues going on with the case. They felt the staff were distracted by external factors and did not address allegation appropriately. The team's review found that the disposition on the case was not properly considered and not thoroughly assessed and that all allegations in the case were not explored.	• A referral was needed to the local family violence program to address ongoing family violence. • Referrals should have been made to agencies for parenting classes, behavior management. • A referral to the CART was needed for these children. • The "special needs" label used in the case on the children was disputed. • The case was Ruled-out, however the case should not have been dismissed so readily and more efforts made to verify the initial outcry by contacting the reporter, teachers, and other school personnel such as the nurse, counselor, • More training is need on adverse childhood experiences and staff should become familiar with these and incorporate this knowledge when making case decisions.