House Select Committee on Child Protection

Interim Charge Presentation

Judge John Specia, DFPS Commissioner

September 30, 2014
Presentation Overview

- Review of Child Abuse & Neglect Fatalities
- Coordination and Collaboration
- Prevention Efforts that Target Resources to Families at Risk
Part One
Review of Child Abuse & Neglect Fatalities
Child Fatalities in FY 2013

**804**
Reported Child Fatalities Statewide (Includes CCL, CPS, RCCL)

**648**
Fatalities unsubstantiated as child abuse or neglect

**156**
Confirmed child abuse or neglect related fatalities

**84**
No prior CPS history

**49**
No CPS case at time of death

**72**
Prior CPS history

**23**
Open CPS case at time of death

In FY 2013, CPS completed 160,240 investigations of abuse or neglect
• In child fatality cases, factors that presented safety threats to the child included:
  o Lack of protective capacity of the caregiver
  o Repeat maltreatment to the child
  o Access to a swimming pool
  o Access to a firearm
  o Inappropriate sleeping arrangements

• Children age three and under represent 80 percent of all child fatalities from abuse or neglect
Child Fatalities

Child Fatalities in Texas
FY 2013
Total - 156

Abuse fatalities include:
- Blunt Force Trauma
- Stabbing
- Suffocation

Neglect fatalities include:
- Drowning
- Unsafe Sleep
- Medical Neglect

Abuse 41% (64)
Neglect 59% (92)
Child Fatalities by Year

Reported Child Fatalities

Confirmed Fatalities Due to Abuse or Neglect


1024 1016 1024 973 882 804 773

213 280 227 231 212 156 *

*Preliminary FY2014 numbers are subject to change.
Causes of Child Abuse/Neglect Fatalities

Causes of Child Abuse & Neglect Fatalities

- Neglect to Child
- Physical Abuse to Child

Axis Title

FY2010  FY2011  FY2012  FY2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Neglect to Child</th>
<th>Physical Abuse to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2010</td>
<td>134</td>
<td>93</td>
</tr>
<tr>
<td>FY2011</td>
<td>129</td>
<td>102</td>
</tr>
<tr>
<td>FY2012</td>
<td>122</td>
<td>90</td>
</tr>
<tr>
<td>FY2013</td>
<td>92</td>
<td>64</td>
</tr>
</tbody>
</table>
Age of Child Abuse & Neglect Fatality Victims

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Newborn through 3 months</td>
<td>17%</td>
</tr>
<tr>
<td>4 to 12 months</td>
<td>24%</td>
</tr>
<tr>
<td>1 - 3 years</td>
<td>40%</td>
</tr>
<tr>
<td>4 - 6 years</td>
<td>6%</td>
</tr>
<tr>
<td>7 - 9 years</td>
<td>11%</td>
</tr>
<tr>
<td>10 - 17 years</td>
<td>2%</td>
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In FY 2013, DFPS Internal Audit was directed to conduct an audit of the existing child fatality review processes. The audit found that DFPS needed to make efforts to identify lessons learned and ensure the agency has a clear and consistent response to each fatality. In particular, it was noted that policy and procedures are maintained in multiple documents and not consistently presented in a logical flow, which requires staff to piece together information from various places to perform their job functions.
• DFPS developed a child safety action plan that includes audit recommendations, responses to specific child fatality cases, identified trends, or a recommendation from a child safety forum with providers.

• Areas addressed in the child safety plan include:
  o Child fatality review process
  o Kinship Care
  o Foster Care
  o DFPS training and casework practices
  o Regulation of contracted providers
• In response to the audit findings and recommendations, DFPS overhauled the child fatality process to be more consistent, transparent, and comprehensive:
  o Restructured the child fatality review process and clarified the role of external reviewers to ensure thorough review of fatality investigations.
  o Streamlined and clarified internal fatality review policy and protocols to ensure consistent application across all regions. Consolidated all fatality related procedures into a separate manual.
  o Implemented centralized, comprehensive data collection that allows for real time analysis of fatalities.
  o Established an ongoing process to analyze issues and trends identified during child fatality reviews in an effort to prevent child fatalities.
In FY 2013 there were 3 fatalities in kinship care. Each of the 3 fatalities was related to improper supervision. To address concerns, during the last year DFPS:

- Updated the manual provided to all kinship caregivers to include more information on ensuring child safety.
- Reviewed kinship policies, procedures, and rules to ensure that they are up-to-date and that safety is emphasized.
- Strengthen ongoing assessment of child safety risks during home visits.
- Conducted an additional safety check on all children aged 3 and under who are in kinship placements.
- Updated the DFPS home assessment for kinship placements to ensure that caseworkers clearly identify risks during the family’s home study and take appropriate steps to address those identified risks.
- Publishes a quarterly newsletter for Kinship Caregivers.
In FY 2013 there were 7 fatalities in foster care. With 90 percent of children in foster care placed with private providers, how DFPS regulates and monitors those providers is critical. DFPS took the following actions:

- Conducted child safety forums with providers across the state (completed December 2013);
- Strengthened minimum standards related to the screening of foster parents; and
- Conducted a contract monitoring audit to assess the process for evaluating residential provider performance, with a focus on child safety and quality of care (Completed July 2014)
• The contract monitoring audit recommended the development of a risk assessment instrument based on predicative analytics, an evidence-based statistical technique that analyzes data to forecast the likelihood of future events or behaviors.

• In August, DFPS began using an improved risk assessment instrument to better promote child safety.

• The goal is for contract staff to prioritize which residential contractors and risk factors to monitor.
In 46% of child fatalities, CPS had prior involvement with the family. In order to ensure CPS workers have the training to identify safety risks, DFPS is taking the following steps:

- Conducted a statewide training on safety for all CPS foster/adopt staff. (Fall 2013)
- Updated training for caseworkers on identifying and addressing safety concerns with focus on better communication between CPA and CPS staff. (Spring 2014)
- Increased training for Human Services Technicians (HST) to enhance their abilities to recognize safety issues. Since HSTs are an additional set of eyes on children and often transport children to services, they serve as another opportunity to observe and ensure that child’s safety. (Spring 2014)
Part Two
Coordination and Collaboration Efforts
Coordination and Collaboration

- DFPS is strengthening partnerships and engaging in information sharing to help locate missing children.
- Earlier this month, DFPS entered into a Memorandum of Understanding that will authorize the National Center for Missing and Exploited Children (NCMEC) to produce a missing child poster when a child is lost, abducted or missing from state care.
- In addition to working with 300 corporate photo partners to do a targeted dissemination of a poster, NCMEC brings their many other resources to bear, including analytical tools and data sources to help find the child.
- Because NCMEC is a national clearinghouse for both missing and sexually exploited children, they are able to connect potential victims and offenders in multiple states.
• Child advocacy centers can be helpful in identifying cases that require the attention of DFPS as well as law enforcement in order to strengthen joint investigations.

• Beginning in mid-August, Statewide Intake initiated a pilot program with the Child Advocacy Center (CAC) of Smith County in Tyler.

• Law enforcement notifications are sent to the Tyler Child Advocacy Center as well as law enforcement in order to involve the CAC in joint investigations with CPS and law enforcement in a more timely manner and make recommendations for more effective joint investigations.
Coordination and Collaboration

• DFPS continues to support current, active Family Drug Courts across the state as well as continues to work to expand Family Drug Courts to additional areas.

• Currently, there are 11 active Family Drug Courts across the state that serve families with open CPS cases either through Family Based Safety Services or through Conservatorship.

• Most recently DFPS and DSHS has worked to expand the Drug Court in Bexar County through increased funding available through DSHS along with a commitment to serve more families through the Drug Court program in Regions 1, 8 and 11.
Data-Sharing Partnerships with DSHS

• Helping through Intervention and Prevention (HIP) is a matching project where parents who have experienced a child death are matched with birth file to assess whether that parent has had another child since the death of the first child. The purpose is to provide DFPS with the information to identify high-risk families and offer services.

• Matching all abuse and neglect deaths identified by DFPS with data sources at DSHS, including birth and death data.
CPS has **conservatorship**; Faith organizations have **stewardship**; and Communities have **ownership**.

~ Bishop Aaron Blake ~

Brownwood, TX
Churches Have Joined the Effort

Faith-based organizations help with prevention, foster/adopt, and youth transitioning to independent living

- Currently there have been 149 churches recruited to participate in the Faith Based Collaboration.
- As of September 2014, 113 churches attended informational meetings with the intent to develop and launch Faith Based ministries in the future.
- 16 churches have begun recruiting foster/adopt families.
- 13 other Orphan Care Ministries have been launched.
- DFPS launched a web-based communication tool for front line staff to make requests directly to churches called The Care Portal.
Outreach Efforts

• In the past year, DFPS Office of Consumer Affairs (OCA) reached out to the following organizations to inform them about the role of OCA in reviewing concerns and complaints to encourage them to report any issues that affect children in care.
  – Court-Appointed Special Advocates (CASA)
  – Foster Family Association
  – Child Placing Agencies
  – Foster Youth
Part Three
Prevention Efforts that Target Resources to Families at Risk
Based on Rider 30 funding for innovative prevention services and with early stakeholder involvement, PEI created:

**Project HOPES:**

*Healthy Outcomes through Prevention and Early Support.*

To build HOPES, DFPS convened a stakeholder workgroup to develop a comprehensive plan that utilizes the best strategies for meeting the legislated requirements of the other at-risk prevention services.

These stakeholders advised that the best use of limited dollars would be to target:
- the most at-risk areas of the state; and
- families with children from birth to age five.
Targeted Geographic Areas

• Counties were ranked based on:
  • Child abuse and neglect fatalities,
  • Child poverty,
  • Substance abuse convictions and treatment facility admissions,
  • Domestic violence convictions, and
  • Teen pregnancy rates.

• Children from birth to age five were targeted as they are the most vulnerable to child abuse and neglect and especially fatalities.
Targeted Geographic Areas

- Funding allowed for eight counties to apply for funds and the ones targeted for HOPES are:
  - **Potter** (Amarillo)
  - **Webb** (Laredo)
  - **Gregg** (Longview)
  - **Ector** (Odessa)
  - **Cameron** (Harlingen)
  - **Hidalgo** (McAllen)
  - **Travis** (Austin)
  - **El Paso** (El Paso)
DFPS currently measures programmatic effectiveness using:

1. A validated pre and post services survey of these protective factors; and

2. Entry into the child welfare and the juvenile justice system (if applicable).

DFPS is currently exploring further measures of program effectiveness through a contract with the UT School of Social Work.

UT will evaluate the effectiveness of HOPES as well as make recommendations for future programmatic evaluation and data collection based on historical PEI data and a national review of other prevention programming effectiveness measures.
Next Steps for PEI

1. As of September 1\textsuperscript{st}, PEI reports directly to the Commissioner, as recommended by the Sunset Advisory Commission.

2. PEI is beginning the process to develop a five-year strategic plan for preventing child abuse and neglect.