



June 21, 2019

Dear CAPTA Panel Members,

Thank you for your service to the children and families of Georgia. As you know, recent changes in federal and state law and policy, including the passage of the Family First Prevention Services Act, the opening of Title IV-E funds for legal representation for parents and children, and the passage of HB 472, the Alternatives to Foster Care bill, have created a number of opportunities for the Division to advance our work and to join with you in pursuit of systemic improvements in the state's response to child abuse and neglect. As we undertake the challenging work of implementing the new laws and policies, your mandated role in the evaluation of the extent to which the State is effectively fulfilling its child protection responsibilities is vital. I value the contributions you make both through formal Panel recommendations and through the extensive collaborative work done on an ongoing basis between panel members and the agency.

Attached you will find the agency's response to the 2018 Panel recommendations. I am pleased to recognize that many of the areas highlighted in your report are ones the agency is already working to improve. We will incorporate your feedback into existing plans and engage with you to align and strengthen our efforts to achieve the desired outcomes.

Thank you again for your commitment to the citizens of Georgia.

Sincerely,

A handwritten signature in black ink, appearing to read "Tom C. Rawlings".

Tom C. Rawlings

Division Director



Georgia Division of Family and Children Services

2018 Child Abuse Prevention and Treatment Act (CAPTA) Panel Recommendations & Agency Response

June 21, 2019

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Child Protective Services Advisory Committee Recommendations

Worker Safety Committee:

Recommendations:

Policies	Procedures	Practices
<p>State leadership's commitment to creating a culture of safety both in the field and in the office environment, physical, emotional, and psychological.</p> <p>Budget funds specifically for mandatory worker safety prevention training <i>upon hire and annually</i>, including funding for education on trauma and a support system to prevent vicarious trauma.</p> <p>Establish incident reporting and analysis system including the ability to have incidents logged with the case in GA SHINES. Behavior concerns and incidents reported on any individual associated with the case would be flagged in GA SHINES.</p> <p>Establish clear definitions of reportable incidents.</p> <p>Establish a safety plan to include creation of a Worker Safety Committee and a system of open communication.</p> <p>Evaluate training needs annually based on incidents reported, open communication and recommendations from the Worker Safety Committee.</p>	<p>Develop shared agreement of standards for worker safety.</p> <p>Create a Worker Safety Committee: establish its purpose and include appropriate stakeholders and field agents from all sectors across the state, department leadership and members of law enforcement.</p> <p>Develop a written procedure for pre-visit risk assessment and protocol based on outcome of assessment.</p> <p>Develop written procedures for Field Safety Checklist and protocol for use.</p>	<p>Worker Safety Committee meetings and recommendations from committee reviewed annually.</p> <p>Routine use of pre-visit risk assessment according to recommended protocol.</p> <p>Routine use of Field Safety Checklist according to recommended protocol.</p> <p>Non-punitive approach to incident reporting.</p> <p>Positive promotion of self-care activities at all Division levels.</p> <p>Use of open communication among peers and supervisors for continuous quality improvement regarding safety of employees and clients.</p>

Division Response:

Supporting staff and implementing just culture, a model of shared accountability in which organizations are accountable for systems and how they respond to staff behaviors fairly and

justly are top priorities for Division leadership. These priorities are reflected in recent organizational structure changes, and will be articulated in both the upcoming CFSP, Strategic Plan, and revised CAPTA Plan. The Chief Operating Officer has tasked the Safety Services Director and State Emergency Management Coordinator with reviewing these recommendations in depth and creating a plan to operationalize them. They will also be shared with teams engaging in workforce development tasks, including the NCWWI Workforce Excellence project team. The Division will provide a comprehensive response to its approach for implementing these recommendations at the Annual CATPA Panel Retreat in September of 2019.

Special Investigations Committee:

Recommendation:

Skilled and well-trained foster or kinship caregivers should anticipate multiple critical incident reports, some of which lead to investigations that, assuming there was no actual maltreatment or neglect, are ultimately unsubstantiated. It is important to acknowledge and prepare temporary caregivers - foster and kin – as well as others who have regular, direct contact with children and youth in foster care, that there is an increased risk of a report of abuse or policy violation due to necessary regulations, escalated child behavioral responses, and heightened scrutiny of care for children in DFCS legal custody. DFCS and providers should prepare caregivers and their families for common situations that may result in a report or policy violation, provide skills and opportunities for de-escalation, and inform caregivers of the prescribed process and need for objectivity.

Division Response:

Information regarding critical incident reports, policy violations and investigations is covered with caregivers in the initial training and assessment process. If a report is received on a foster home, Resource Development/Caregiver Recruitment and Retention staff is engaged at that time to provide direct guidance and support to the family for the period of the investigation and afterwards. The Division is willing to share information currently included in training and provider orientation with the CPSAC to facilitate further discussion about specific information needs to ensure foster and adoptive parents are prepared for these situations when they arise.

Recommendation:

Partnering with CPAs to ensure that they are included, and included early, in the investigation when allegations involve one of their foster homes.

Division Response:

DFCS Policy 6.1: Conducting Special Investigations in DFCS or CPA Foster or Adoptive Homes requires the social services case manager to notify the Director/Designee of a CPA upon receipt of a report involving one of their homes. The policy also outlines further requirements for engaging the CPA throughout the investigation. The Office of Provider Management is also notified of reports and assists investigators in working with CPAs. The Division acknowledges that there may be gaps in implementing this policy and will work to address these through training and guidance in the proposed restructuring of the Special Investigations teams.

Recommendation

Special Investigations require a high level of experience and competence. Individuals charged with investigating reported abuse of children in foster care settings should receive training specific to that role to ensure not only that those caregivers are treated fairly but that children, whether foster or biological, are not further traumatized. It is recommended that the Division

develop standards for special investigator qualifications, design specialized training, and implement a plan to ensure that all designated special investigators receive appropriate training.

Division Response

The Division has a pending plan to create regional Special Investigations Unit teams. Part of this reorganization will include creating position requirements and specialized trainings. The Division is committed to communicating with the CSPAC about these plans and will welcome specific recommendations for position requirements or trainings.

Children’s Justice Act Task Force Recommendations

Child Representation Committee

Recommendation:

In response to recent changes in federal legislation allowing IV-E reimbursement for administrative costs related to legal representation and development of Georgia’s new state CAPTA plan that includes a focus on child representation, the committee recommends that the Division convene a work group that includes, in addition to members of the Child Representation committee, its General Counsel, CIP, OCA, CASA and other relevant stakeholders to assess current practice and coordinate efforts among the various state plans. Current child representation data, CAPTA requirements, and degree of compliance with CAPTA assurances should be evaluated to identify gaps, areas needing improvement and additional opportunities. Based on the results of the evaluation, a plan should be developed to address any legislative changes needed, documentation and reporting requirements, inter-agency data-sharing expectations, training standards and targets for improvement.

Division Response:

The Division agrees that such an evaluation would be beneficial and will work with the appropriate stakeholders to undertake it. Child representation and compliance with CAPTA requirements will be addressed in the forthcoming CFSP and revision of the CAPTA Plan. The agency will incorporate these recommendations into the plan.

Child Abuse Protocol Committee

Recommendations:

1. To address the challenge of Georgia’s large geographic area and frequent turnover of professionals involved in the response to reports of child abuse, by exploring alternatives to ‘in-person’ events for disseminating information and providing training on the CAP should be explored.
2. Develop a mobile-friendly version of the CAP to increase the local use of the protocol and the efficiency of disseminating regular updated versions.

Division Response:

The Division recognizes the barriers to consistent utilization of the CAP throughout the state identified by the committee and agrees that alternate methods of disseminating information regarding the child abuse protocol and a mobile friendly version would alleviate some of them.

The Division will work with the Office of the Child Advocate to develop a plan to implement these recommendations.

Mandated Reporter Committee

Recommendation:

The committee recommends that the Division conduct an evaluation of the state's 24-hour call center to assess not only the quality of reports by mandated reporters but also the subsequent assignment of and response to those reports by the state.

Division Response:

The Division has an active Rapid Process Improvement (RPI) in place regarding the CICC call center. The RPI will lead to additional reviews and assessments, including the possibility of a review of mandated reporter reports and subsequent agency responses. The Division is willing to share the RPI procedures with the Task Force and engage in discussion about further assessments needed.

Child Fatality Investigation Committee

Recommendation:

The committee recommends that the Division collaborate with the Office of the Child Advocate, the Georgia Bureau of Investigation, and other stakeholders with relevant expertise to develop and implement a protocol for investigating child fatalities to insure not only that maltreatment-related child fatalities are identified but also to insure that evidence is not compromised in the event that criminal charges are forthcoming. The committee is currently developing a proposed outline for the model protocol for consideration and plans to complete this in 2019.

Division Response:

The Division agrees that there would be considerable benefit to having a consistent protocol for investigating child fatalities and looks forward to receiving the proposed outline for a model protocol. The Division is willing to participate as needed in the development of the outline and will work to engage stakeholders to develop and implement a protocol based on the proposed outline.

Recommendation:

The committee is recommending that a section in the state model Child Abuse Protocol also be developed for first responders/EMS.

Division Response:

The Division appreciates the importance of involving first responders/EMS in a consistent response to child abuse and neglect and will work with the Office of the Child Advocate and other appropriate stakeholders to incorporate a section into the model Child Abuse Protocol.

Child Fatality Review Maltreatment Committee Recommendations

Recommendation:

The Maltreatment Committee continues to advocate for and recommends the reconstitution of a multidisciplinary process that engages a variety of stakeholders and experts in the regular review of maltreatment-related deaths to identify opportunities not only to examine policy,

practice, training and culture but to identify effective prevention strategies to reduce the incidence of maltreatment-related deaths. It further recommends that the Division publish summary findings from these multidisciplinary reviews annually in support of CAPTA's public disclosure intent.

Division Response:

The Division is part of a Nationwide Partnership for Child Safety Collaborative (NPCS). This national quality improvement collaborative includes 11 jurisdictions throughout the country with an aim to prevent tragedies and improve child safety outcomes by using safety science principles. Casey Family Programs is supporting this effort and Chapin Hall is instrumental in its development. Members of this collaborative will share data collected and use a standardized critical incident review model to promote a safety culture. This review process contains 3 critical elements; it promotes psychological safety, encourages mindful organizing and addresses burnout. Part of this process includes involving community partners in a multi-disciplinary review of the case specific data to identify and improve systemic influences to prevent future incidents of maltreatment. Georgia has begun this effort by involving the Georgia Bureau of Investigations, State Child Fatality Review, Prevent Child Abuse Georgia, Department of Public Health, Office of the Child Advocate, CAPTA Panel Members, Children's Health Care of Atlanta and Georgia State University into this process. As this develops, additional external partners will be included as they are pertinent to case reviews and the Quality Improvement piece of this work will be implemented as aggregate data is collected and analyzed.

Recommendations:

1. The Maltreatment Committee suggests that without a fiscal note in the state budget to provide additional resources for GBI/OFCR, it will be difficult to effect improvement in any problem areas identified by the survey of local CFRs. The Maltreatment Committee recommends that GBI/OFCR budget be increased to provide sufficient resources to meet its legislative mandate.
2. The Maltreatment Committee recommends that the Division partner with the Office of the Child Advocate to review current legislation, conduct research on legislation and best practices for child fatality review in other states and develop recommendations to revise Georgia code.

Division Response:

The Division agrees with both these recommendations and will work with the Office of the Child Advocate as suggested.

