

CWAC – September 18, 2015

Present: Carl Ayers, Alex Kamberis, Deborah Eves, Nicole Shipp, Ericca Facetti, Abigail Schreiner, Lori Battin, Katherine Lawson, Chauncey Strong, Latanya Hairston, Traci Jones, Bragail Williams-Brown, Robin Ely, Jennifer Jones, Melissa O'Neill, Jill Forbes, Judy Gundy, Rita Katzman, Shannon Brabham, Denise Gallop, Tania White, Phyl Parrish, Heather Davis, Rick Verilla, Rebecca Morgan, Dorothy Hollahan, Tonya Christian, Melanie Galloway, Laura Polk, Tiffany Gordon, Carey Natoli

Carl Ayers, Director for the Division of Family Services, opened the meeting and the group provided self-introductions. There was one suggestion for an additional agenda item: update the progress made towards completion of the extending foster care to 21 report that was discussed on during the July 17th meeting. Mr. Ayers requested that each sub-committee report on activities conducted since the last CWAC meeting.

Rebecca Morgan spoke for the **prevention sub-committee**. Ms. Morgan reported the sub-committee sent a 10 question survey to local department directors on prevention services offered. The sub-committee plans to meet monthly and the October meeting will focus on the different types of prevention services being offered across the state. Ms. Morgan reported they sub-committee is still seeking members and was happy to report that someone from Delegate Chris Peace's office will join the sub-committee. Finally, Ms. Morgan shared information about an upcoming workshop, "Child Prevention Services Diversion" which is being led by Christie Marra of the Virginia Poverty Law Center.

Jo-Ann Wilson Harfst and Rita Katzman spoke for the **CPS sub-committee**. The sub-committee had one meeting to date and discussed the option of conference calls for upcoming meetings and development of a charter. This sub-committee is also seeking more members with the current make up comprising state and local workers and a representative from SCAN. The topic of conversation at the first meeting include trauma informed care and the learning collaboratives. A major point of discussion was the use of psychotropic medications on children with CPS involvement.

Abigail Schreiner reported out for the **permanency sub-committee**. Ms. Schreiner is one of several co-chairs and reports several conference calls between the chairs. The first meeting of this sub-committee was scheduled for the same day as the CWAC meeting. The plan was to discuss a scope of work during the meeting.

Sandi Slappey spoke for the **quality assurance sub-committee**. The members made the decision to change the name to the continuous quality improvement sub-committee. Like other sub-committees, they are looking for additional members and would like representation from the central, piedmont, and western regions of the state. The sub-committee had one meeting via conference call and plans to continue meeting through calls. A decision that will be made in upcoming meetings will be the focus of the committee; will the group focus on issues of quality improvement or on specific issues raised by other sub-committees.

A general discussion about well-being issues took place after the sub-committee reports. Alex Kamberis reminded the group that the most recent version of OASIS had been released (version 3.15) and includes

the ability to track psychotropic medications. Latonya Hairston, DMAS, spoke to the group concerning over all compliance with children being seen by a physician within 30 days of entry into foster care. Ms. Hairston shared that according to the data collected, the overwhelming majority of children are being seen yearly and less than 40% were not seen within 30 days of entry. DMAS is partnering with Health Services Advisory Group to look at the foster care populations medical needs and create a report that should come out in summer 2016. DMAS is planning on documenting the process local departments go through to get a child seen by a physician within 30 days to see if there is a way to enhance the process.

The next agenda topic was **Learning Collaboratives and Practice Profiles**. Mr. Ayers informed the group that work was being done to finalize the agenda for the third learning collaborative meeting which is scheduled for October 18-19. The focus of this collaborative is on coaching. Mr. Ayers reminded the group that the first learning collaborative meeting focused on practice profiles and the second meeting applied a "trauma lens" to the profiles. It is anticipated that the practice profiles will be completed by the meeting in October and they will be rolled out across the state next year. There are 12 areas of focus in the practice profiles. This may be condensed more but for now those areas of focus are: Advocating, Assessing, Collaborating, Communicating, Demonstrating Cultural and Diversity Competence, Documenting, Empowering, Engaging, Evaluation, Implementing, Partnering, and Planning. In the practice profile, each area of focus is defined and broken into skill sets. Each skill set has examples of optimal practice, developmental practice, and unacceptable practice. These profiles should be used by supervisors to support practice when working with family services workers.

Feedback from the group was positive. It is seen as a positive that workers from 22 LDSS were an integral part of creating the practice profiles. That "bottom up" approach should help with buy in from other local workers. The group was very supportive of including training along with the roll out of the profiles. A person who had been involved in the development of the profiles and the learning collaborative shared that the process of creating these documents started off frustrating but that frustration had eased. There was a question from the group about how the profiles will be measured. There is currently no measurement set. The plan is to work with Casey Family Programs to develop measurements.

Rita Katzman reviewed the **preliminary report for child fatalities** that were reported to LDSS during 2014. In SFY 2014, the Regional Child Fatality Review Teams conducted reviews of all child deaths which occurred in SFY 2013. The results of that review and their recommendations are anticipated to be published by December 2015. LDSS investigated 124 reports of child deaths suspected to be caused by child maltreatment in SFY 2014, which is 18 more than the previous year. It doesn't mean that there were 18 more cases where children died as a result of abuse or neglect, but an increase in those being reported and investigated by LDSS. Of the reports received, 47 were founded and 73 were unfounded. One report is pending and three reports are on appeal. Fifty-six (47%) of 120 LDSS investigated at least one child death. Norfolk, Hampton and Richmond City had the highest number of investigations, not all of which were founded. The number of children who died compared to the total population of children in Virginia did increase from SFY 2013: 1.8 to 2.5 per 100,000 children. In contrast, the national death rate decreased from 2.2 in 2013 to 2.0. The National Child Abuse and Neglect Data System (NCANDS) 2013 data (based on Federal Fiscal Year 2013) documents that Virginia's rate of founded child

maltreatment deaths had been equal to or slightly lower than the national average until this year. There is no national data for 2014 available to date. The increase in the child death rate in Virginia may be a result of more investigations being conducted by LDSS in response to the fatality review process that was implemented statewide in 2012. According to the 2013 Child Maltreatment report, many states reported increased counts of child fatalities and attributed the increase to better reporting and implementation of child death reviews.

Child Death Investigations and Outcome by Region

Region	Investigated	Founded	Unf.	Pending or Appeal
Eastern	47	17	30	0
Central	16	5	11	0
Piedmont	24	8	15	1
Northern	27	10	15	2
Western	10	7	2	1
Total	124	47	73	4

The Eastern region continues to investigate the most child deaths. Investigating and making a founded disposition are two different things. The percentage of founded cases for Eastern is 36%. The Western has a much higher percentage of cases that are founded at 70%. The percentage of founded versus unfounded by region mirrors the dispositions made in all child abuse and neglect investigations statewide in SFY 2014 with the exception of the Western region. The Western Region had a higher percentage of founded dispositions for child deaths compared to all investigations. The percentage of founded investigations by region is: Central- 41%; Eastern- 40%; Northern- 31%; Piedmont- 44%; Western- 41.5%.

Child Death Rate by Region

Region	Deaths	Per 100,00
Eastern	17	4.1
Central	5	1.7
Piedmont	8	3.4
Northern	10	1.2
Western	7	6.3

There was an increase in all regions, except Western, in the ratio of child deaths to the population of children less than 18 years of age. Of the 47 children in Founded investigations, the majority (approximately 75%) were under 4 years of age.

Race of Child

Race	Number	Percent
African-American	12	25.5
White	27	57.4
Multi-racial	6	12.8
Asian	2	4.3
Total	47	100.0

There has been a significant decline in the number of African American children represented in this report since 2010 when 50% of the children were African American. In 2013, the percentage dropped to 40% and this year saw a decrease to approximately 25%. This percentage is actually representative of the overall percentage of African Americans in Virginia.

Caretakers - Relationship

Caretaker Type	Number	Percent
Mother	29	48.3
Father	16	26.7
Step-parent	2	3.4
Grandparent	4	6.7
Paramour	5	8.2
Babysitter	3	5.0
Total	60	100.0

There were 60 caretakers responsible for the 47 child deaths. Some children were abused by more than one caretaker. Most caretakers were related to the victim or resided with the victim. Seventy-five percent of caretakers were biological parents. The number of biological mothers as perpetrators almost doubled since 2012 (15). Of the four grandparents, three were grandmothers. The ages of caretakers in SFY 2014 ranged from 20 to 65 years of age. The majority of the caretakers (47%) were between 20 to

29 years of age. SFY 2014 had an increase in the number of caretakers over 50 years of age, with three of the six being grandparents.

Of the children who died, half (50%) had been physically neglected; 28% were physically abused; 15% were both abused and neglected; 7% medically neglected. The type of abuse or neglect is not necessarily the cause of death for the child. Cause of death is a term used by the medical examiner. For example, one child was not being supervised and shot himself. The manner of death was ruled accidental; the cause was gunshot wound; the type was neglect – an act of omission. CPS uses these categories to define acts of omission or acts of commission. Almost 60% of the children who died, died from some form of neglect. Consistent with past years, the most prevalent type of neglect is lack of supervision. A lack of supervision involves a child being left in the care of an inadequate caretaker or in a situation requiring judgement or actions greater than the child’s level of maturity, physical condition, and/or mental abilities would reasonably dictate. A lack of supervision resulted in deaths of five children in unsafe sleep environments; four children overdosed on drugs; two children died in car accidents; two children shot with an unsecured weapon; two children left in a car for extended time; and two children left in the care of other children too young to babysit.

Initial Safety Outcomes for Other Children in the Home

Safety Outcome	# Families <i>not children</i>
Emergency Removal/Foster Care	10
Relative Placement w/ Safety Plan	15
Remain in the Home w/ Safety Plan	5
Total Families (not children)	30

Of the 47 child death investigations resulting in a founded disposition in SFY 2014, 30 families had other children for whom initial safety was assessed. Ten families had siblings removed from the home and placed into foster care. This is an increase from past years. In 2013, there was only one child removed and placed in foster care. This is an area that the regional fatality review teams will be asked to get additional information. Fifteen families made arrangements for siblings to stay with relatives while the investigation was conducted with the LDSS then monitoring their safety. Five families had siblings who remained in the home with a safety plan that was monitored by the local department. The remaining 17 cases did not have any siblings of the deceased living in the home.

Prior Abuse and/or Neglect

Prior Abuse/Neglect	Number	Percent
Yes	20	42.6
No	27	57.4
Total	47	100.0

Of the 47 victims in founded CPS fatality investigations in SFY2014, there were 20 families (42.6%) with prior child welfare involvement or open child welfare cases. Previous years there were fewer cases but the percentage was similar. (2013- 42%; 2012- 39%) Over the past three years, prior involvement has been around 40%. Prior involvement may mean that the abuser, victim, or siblings were previously or currently the subject of a family assessment, an investigation, or an CPS ongoing, prevention, or foster care case.

Unfounded cases also provide information that can help guide practice. Unfounded means there was not a preponderance of the evidence to support making a founded disposition. It does not always mean there was no abuse or neglect. For unfounded cases, 51 of 73 (70%) involved a child under one year of age and 48 of 73 (66%) were related to the sleep environment. By far, the most reported unfounded deaths involved those related to unsafe sleep environments. This may mean the actual surface the child slept on, with whom the child was sleeping with, or how the child was sleeping. This includes children who suffocated or accidentally asphyxiated due to their sleep environment.

Ms. Katzman wrapped up the presentation with the numbers of child investigations to date. As of September 4, 2015 there have been 131 investigations. Thirty-eight have been founded. Forty-eight have been unfounded and 45 are pending.

Carl Ayers provided information about the **Memorandum of Agreement (MOA)** between the Department of Juvenile Justice (DJJ) and DSS. DJJ approached the Children's Cabinet about the roles and responsibilities of DJJ and the LDSS to serve the best interests of juveniles who are committed to DJJ and who were in the custody of the LDSS immediately prior to commitment. In an attempt to understand the issue, data was shared between social services and DJJ which helped to clarify the number of youth this affected. Both DJJ and VDSS are committed to identify solutions and agreed to create this MOA.

The MOA applies to the procedures applicable to DJJ and guidance to the LDSSs for case management of juveniles prior to, during, and following commitment to DJJ if the juveniles were under the age of eighteen and were in the custody of the LDSS prior to commitment. The MOA applies for the duration of commitment to DJJ, regardless of the direct care placement facility. The MOA is for youth who will return to foster care from DJJ custody prior to their 18th birthdays. If a youth is over age 18 when he/she is released that person could qualify for independent living services, not foster care. Prior to a youth's commitment, the LDSS has custody and should attend delinquency hearings and work with court services units by providing requested documentation and assessments. After the juvenile has been

committed, the LDSS should coordinate a family partnership meeting, to include the youth in person or by video if possible, within five days. LDSS should continue with monthly visits. Every other month visits occur in person. The months the visit is not in person, visitation should be conducted through video conference. CSU parole officers are encouraged to meet with the youth at the same time as the family services worker. DJJ will keep the local department up to date on the youth and keep the LDSS apprised of the juvenile's anticipated release date to facilitate the scheduling of Family Partnership meetings. The LDSS is responsible for communications with the family during this time.

A Family Partnership meeting shall be held six (6) months prior to and ninety (90) days prior to the juvenile's anticipated release date. The LDSS shall take the lead in coordinating the meetings. Meetings shall be located in the community to which the juvenile is anticipated to return, and the juvenile shall be permitted to participate by telephone or CSU video conference technology. LDSS should file the petitions for foster care review hearing and permanency planning hearing 30 days prior to the anticipated release date.

Mr. Ayers spoke to the additional agenda item, Fostering Futures, requested at the beginning of the meeting. He talked to the group about why there was a need to select a name other than "Fostering Connections". Fostering Connections and foster care to 21, as it has also been called, implied the continuation of services that were offered to youth under the age of 18 even if those services had already been proven ineffective. Youth in foster care were asked to come up with a new brand; something that more accurately captures the intent of the legislation. Fostering Futures was chosen because it captures the hopeful nature that is embodied in the legislation. The goal is to help youth become productive adults and continuation of the right services will foster opportunities. Once again, VDSS is proposing legislation to extend foster care service to youth up to the age of 21. The proposed legislation to General Assembly has three options for implementation. These three options include a three year phased in approach; allow for all youth to utilize it once it is passed; or fund it at the expected participation rate. More information, as it is known, will be shared with CWAC.

The meeting concluded at 1:00 pm. The next meeting is scheduled for November 13, 2015. Please note that this is a change in date. Normally, the meeting would be held on November 20, 2015, however, due to the learning collaborative schedule CWAC has been moved up by one week. The meeting will be held from 10:00 – 1:00 at the Twin Hickory Library in Henrico County.