Child Protective Systems Oversight Committee

Annual Report 2017

An annual report to the Sacramento County Board of Supervisors from the Sacramento County Children's Coalition, Child Protective Systems Oversight Committee.

Acknowledgements

The Sacramento County Child Protective Systems Oversight Committee[1] (Oversight Committee) of the Sacramento County Children's Coalition studies and monitors the state of the child protective systems in Sacramento County, at the behest of the County Board of Supervisors, by addressing issues identified in reviews of critical incidents (death and near death occurrences) and/or reviewing organizational issues and practices within the general child protective system.

All of the information outlined in this report is general and does not purport to be related to any particular case, person, or occurrence. A Sacramento County Superior Court order prohibits members of the Oversight Committee from disclosing specific confidential case information.

The Oversight Committee wishes to thank the Sacramento County Departments of Child, Family and Adult Services (DCFAS) and Health Services (DHS), formerly the Department of Health and Human Services (DHHS), especially Dr. Sherri Heller, Michelle Callejas, and their staff, for being responsive to the inquiries made by the Oversight Committee and for their willingness to make continual improvements. The committee also wishes to thank Children's Coalition/DCFAS staff person Abigail Nosce for the technical assistance she provided in putting this report together and for her support to the Oversight Committee. The collaborative culture between these departments, Child Protective Services (CPS), and the Oversight Committee is essential for the improvement of the safety of children and families in our community.

[1] See Appendix A for members of the Oversight Committee.

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History and Role of the Child Protective Systems Oversight Committee

The Sacramento County Children's Coalition, established by the Board of Supervisors (BOS) in 1994, is charged with assessing community needs and evaluating existing services related to the health and well-being of children. By resolution of the BOS, the Children's Coalition is responsible for, among other things, providing community oversight of the County's child protective systems through its Child Protective Systems Oversight Committee.

In January 1996, the County Executive appointed the Critical Case Investigation Committee (CCIC) and charged it with examining and evaluating the child protection system in the context of its nexus to the homicide of Adrian Conway. Its primary purpose was to examine the Conway case to evaluate the efforts of all service providers, including DHHS, Family Preservation and Child Protection Division.

In May of 1996, the CCIC issued its final report. It recommended establishing within an existing community advisory group the function of "community oversight of child protective services, including preparation of an annual report to the BOS on outcomes and effectiveness of the system along with recommendations for policy and program changes." It identified a nonexclusive list of areas that the annual report should address:

- Findings from the Child Death Review Committee and assessment of impacts on the child protection system;
- Overall statistics and program analysis;
- A quality assurance review of at least one operational unit in the child welfare system;
- Comparison of outcomes for children with other communities in the state and nation;
- Identification of exemplary programs and practices with recommended application to the County;
- Report on community satisfaction with the child protections system; and
- Review and report on progress on recommendations contained in the CCIC's report.

In July 1996, the BOS approved DHHS' recommendation that the BOS appoint the Children's Coalition as the oversight body called for by the CCIC; and the Child Protective Systems Oversight Committee (Oversight Committee) was established. The bylaws of the Children's Coalition define the duties of the Oversight Committee. The committee is responsible for performing community review of critical Child Protective Services cases, culminating in an annual report that includes outcomes and effectiveness of the system, with recommendations for policy or program changes. The report may also include review of progress on the recommendations contained in the CCIC report and other items identified in the 1996 CCIC report. The report is approved by the Children's Coalition and is presented to the BOS annually.

The Oversight Committee is not limited to oversight of the County's CPS Division. It can, in its discretion, expand its inquiry to the County's child protective services system generally, including service providers under contract with the County. Such an examination would necessarily be more systemic in character, as access to an individual's records would be limited based upon a spectrum of confidentiality laws. The Juvenile Court order allows access only to those records that fall within the purview of Welfare and Institutions Code section 827, i.e., records related to dependency proceedings. Ultimately, the decision as to the focus and extent of its oversight functions rests within the exclusive determination of the Oversight Committee, subject to any limitations in the Children's Coalition bylaws or BOS action.

Annual Report 2017

I. Introduction

The Child Protective "Systems" Oversight Committee focuses on agencies and organizations within our community that play a role in ensuring the safety of children. Multi-agency collaboration is an essential component of child protection. This year's report continues the committee's focus on collaboration and the importance of child serving agencies and organizations working together to form a stronger safety net for vulnerable children.

Following the Oversight Committee's 2016 Annual Report, the Board of Supervisors (BOS) allocated resources to address needs identified by the Oversight Committee. These resources were used to increase the CPS Hotline's Intake staff by one unit (six workers and one supervisor), expand supervisor duties to cover the weekend shifts, and continue refinements to the CPS Hotline's menus and caller experience. The Oversight Committee has observed progress in these areas and wishes to thank the BOS for their support.

II. 2017 Presentations to the Oversight Committee

In an effort to help increase collaboration between systems serving children, and to become more familiar with the services available, the Oversight Committee identified community agencies and organizations charged with ensuring child safety or providing resources or services that contribute to improving the health and well-being of the children and families in the community. The committee invited these agencies and organizations to present information about what they do and how they collaborate with other entities. The committee received the following presentations. Meeting minutes and handouts can be found at:
http://www.dcfas.saccounty.net/Admin/childrenscoalition/Pages/ChildrensCoalition_Home.aspx.

March 2017: Sacramento County DHHS Ombudsman

DHHS Ombudsman/Civil Rights Coordinator Susan Anderson educated the committee about her role. The Ombudsman is a neutral party who helps to resolve complaints or answers questions about Health and Human Services departmental policies and practices. Her role as Civil Rights Coordinator mainly involves answering questions about court orders and helping people understand the process. In this role, she also monitors DHHS sites' compliance with civil rights laws. The Ombudsman receives calls for a variety of reasons including: complaints about how a CPS case is being handled, mental health resources when existing have been exhausted, adoptive family issues with payments, parents with open CPS cases inquiring about where their children are, complaints about In-Home Supportive Services, and calls regarding issues not within the scope of Sacramento County DHHS.

How the Ombudsman can help:

- Provides information, answers questions, and identifies staff or resources to address issues
- Researches departmental policies and procedures that may assist in resolving complaints
- Facilitates prompt resolutions in an independent, impartial, objective and professional manner
- Assures matters are treated in a confidential manner, as appropriate

What the Ombudsman cannot do:

- Does not have the authority to overturn a court decision or make recommendations to the court
- Cannot investigate matters when appeals or law suits are pending against the County
- Unable to give legal advice
- Cannot ensure implementation of any recommendation made following their investigation
- Personnel and disciplinary matters are referred to a department manager for the appropriate action

Other help the Ombudsman provides:

- Attends meetings with people, acting as a neutral third party, for support
- Helps people understand if their rights were violated
- Connects people with resources that may help them resolve issues that are outside the scope of Sacramento County DHHS
- Lends a sympathetic ear to people needing to talk through their problems
- Empowers people to voice their concerns and take action to resolve problems

July 2017: California Children's Services, CPS Medically Fragile Review Team, and CPS Medically Fragile Unit

California Children's Services (CCS)

Ayanna Edmonson, RN spoke about her role as liaison between CPS and California Children's Services (CCS). CCS is a California State program that helps pay for services or equipment for children with certain diseases, physical limitations, or chronic health problems. Families must meet certain requirements to be eligible for the program. CCS program staff provide medical case management and connect families to CCS-approved medical specialists for care.

- In addition to having access to the network of CCS-approved specialists, clients can access care through CCS clinics located at three different schools in Sacramento County.
- Clients with complex conditions are followed by CCS Special Care Centers that provide multi-disciplinary services.
- CCS can access medical records for children seen at a variety of hospital systems. There is also a contact at each major hospital system that CCS can reach out to for information.
- The CPS/CCS Liaison is a half-time position that works for both CPS and CCS, but is housed at CCS.
    - The liaison interfaces with both agencies to share information that they would not otherwise be able to easily access.
    - The liaison also serves as a resource to CPS Social Workers (SW) by educating about program services, criteria, and how to refer medically fragile clients, and assisting in collecting information about their mutual clients.
    - CPS SWs and Public Health Nurses (PHN) can contact the liaison at any time to receive information about clients.
    - Monthly caseload reports identify mutual clients. This report helps the CPS/CCS liaison track and monitor mutual cases. (There were roughly 200-250 mutual cases between CPS and CCS at the time of this presentation.)

CPS Medically Fragile Unit (MFU)

CPS Program Planner Keeva Pierce spoke about the work of the Medically Fragile Unit and Medically Fragile Team. The MFU is part of the Emergency Response (ER) Program. The ER program is comprised of seven SWs and one Supervisor. Two of these SWs are well versed in medical conditions, diagnoses and medical systems, are specifically dedicated to handling medical neglect referrals, and work closely

with PHNs to make assessments. One PHN is dedicated specifically to work with the MFU; however, four to five PHNs are assigned to the ER Program, as a whole.

CPS Medically Fragile Review Team (MFRT)

The MFRT meets twice a month to discuss cases referred to them by SWs. The MFRT includes ER Program Specialists, the CCS/CPS Liaison, a representative from Alta California Regional Center, a PHN Supervisor, the Medically Fragile ER Supervisor, the Medically Fragile Informal Supervision Supervisor, and the SW handling the case.

- It is a requirement that MFRT review all medically fragile cases and/or referrals with allegations of medical neglect prior to closure.
- Policies to guide SWs on doing comprehensive investigations for medical neglect and making referrals to the MFRT for review are being developed.
- All new SWs receive training on the role of the MFRT and how to make referrals. All SWs and Supervisors receive refresher trainings and emails periodically, reminding them to use the MFRT.

III. Critical Incidents Subcommittee Report

The Critical Incidents (CI) Subcommittee is comprised of community stakeholders who are professionals in the field of child and family services and child protection. This subcommittee meets monthly to review a subset[2] of maltreatment child fatality and near fatality cases that occur in Sacramento County, wherein the maltreatment child fatality or near fatality was directly related to child abuse or neglect. The purpose for these reviews is to identify cross-systems issues to improve outcomes for children, which may be used by the partners in the child protective systems to improve practice and avoid repeating mistakes of the past.

In addition to its monthly independent reviews, representatives from the CI Subcommittee sit on CPS teams that review the cases described in this report. These internal reviews, facilitated by County CPS, focus on identifying CPS systematic issues that may have contributed to an environment of "missed opportunity" to intervene with families that subsequently experience a maltreatment related to child fatality or near fatality. This Quality Assurance Framework within the CPS organization was a recommendation of the CPS Oversight Committee in its 2012 Annual Report and was initiated by CPS in 2013, when CPS received resources from the Board of Supervisors to build this framework.

In CPS' 2013 proposal to implement its Quality Assurance Framework, it cited the U.S. Administration for Children and Families' Continuous Quality Improvement Memorandum which describes the five components essential to a quality assurance model for child welfare agencies: 1) a sound administrative structure to oversee the QA process; 2) appropriate mechanisms for data collection; 3) a method of conducting case reviews; 4) a process for analyzing and disseminating outcomes data; and 5) a process for providing feedback to stakeholders and decision-makers and for adjusting practices and protocols.

Since 2013, CPS' Quality Assurance Framework has been developed, implemented, and continues to be refined to improve processes. For example, this year, several changes have been made to improve processes. The teams within the Quality Assurance structure now use "root cause analysis" tools, which help to identify recurring issues to be addressed. Additionally, CPS has expanded the use of "case review trainings" so that the lessons learned from the critical incidents are shared with all line staff. Finally, the

[2] Cases fall into the subset if they had Sacramento County CPS involvement in the two years prior to the child fatality or near fatality. Cases that do not meet the above criteria may be added at the discretion of the Director of DCFAS or the Deputy Director of CPS.

"initial investigators" (who review the files and interview involved parties) have expanded from a two-person team into a team of six. This change improves the process by incorporating scrutiny from different programs/areas of expertise, builds agency capacity by expanding the number of people with the skill set to critically assess organizational practices, and provides a line of continuity between the people who conduct the reviews and the people who transfer the lessons learned to the line staff.

Cases Reviewed in 2016-2017

This report highlights the cases reviewed and observations of the CI Subcommittee over a two-year period: 2016-2017. The CI Subcommittee reviewed eight cases. Some of the cases reviewed were complex, having complicated family issues and situations. These types of cases can be difficult to discern facts. However, the committee continues to see areas that need improvement and errors made during the review.

Some of the observed errors included:

- **A lack of critical thinking when making judgements about how to treat cases.** For example, there were instances where CPS Workers and Supervisors did not appear to use information contained in previous referrals and instead relied on information given by parents without verifying it first.
- **Medically fragile children were not always assigned to be served by the Medically Fragile Unit** and PHN to follow up on care with medical providers.
- **The impacts of parental drug use, including the use of legal marijuana, on child safety and well-being were not always adequately assessed.** Follow-up with drug testing compliance may happen when it is court ordered, however, there is no legal mechanism to issue consequences for parental drug use without a court order, creating little incentive for parents to quit drug use (a risk factor among child deaths).
- **A lack of follow-up when closing a referral, ensuring parents are taking advantage of suggested resources** that would support the welfare and safety of the children in their home (i.e. mental health services, drug and alcohol services, and domestic violence services).
- **Some investigations appeared incomplete or closed prematurely.** SW workload continues to be an issue, as caseloads are higher than the Child Welfare League of America (CWLA) Caseload Standards recommend (no more than 12 per worker)[3].
- **A lack of communication between community providers, which leads to missed opportunities to provide the best quality of services to families.** For example, families referred to new services did not always receive a warm hand-off and/or there was no follow-up to ensure they have actually connected to services. **Of great importance is the collaboration among medical staff, social workers and community providers, in order to provide families in crisis with the support and resources they need.**

The CI subcommittee wishes to acknowledge the important work that CPS SWs do and that human error will always be present. The CI subcommittee and the Oversight Committee, as a whole, also wish to acknowledge and highlight the changes seen in the CPS organization over time. It appears CPS is striving to work like a true "learning organization." The CI subcommittee has observed CPS over the last few years to be far more open and transparent than in all years since the inception of the Oversight

[3] California Welfare League of America. (2012). *Direct Service Workers' Recommendations for Child Welfare Financing and System Reform* (p.5). Washington, D.C.: CWLA

Committee. CI subcommittee members working with CPS on its internal reviews have observed that CPS is working to critically assess its operations and develop a willingness to make changes and to continually assess the effectiveness of any changes. This committee believes that this shift in the organization is a direct result of the management style of its leader(s).

Changes Implemented as a Result of QIC's and CI Subcommittee's Reviews

- Increased "case reviews" with Social Work staff and supervisors and Program Managers
- All of management has been trained on critical thinking
- Several steps have been implemented to improve collaboration with PHNs and Social Workers

IV. Follow-up on 2016 Recommendations

Much of the information contained in this section was received from DCFAS Director Michelle Callejas and members of the CPS organization.

2016 Recommendation #1

Provide the Emergency Hotline with PHN resources, which could assist with determining appropriate response times and conclusions on referrals with allegations of medical neglect, and staff training around how to best utilize these resources.

2017 Update for Recommendation #1

As of June 2018, CPS reports that a PHN Supervisor or a Lead PHN is available to consult with the ER Hotline staff and ER Field SWs about medical neglect referrals, as needed, and that its Intake Policy and Procedure (P&P) document has been updated to reflect PHNs' availability for consultations. Additionally, CPS states a P&P has been created to address investigating and serving children with complex medical conditions, which also highlights the importance of SWs partnering with PHNs throughout an investigation and a case. Further, CPS reports additional oversight of medical neglect referrals occurs by a newly hired ER Program Specialist; the ER Program Specialist retrieves data on medical neglect referral assignments bi-monthly and follows up with ER SWs to ensure PHN consultation and a review by the Medical Review Team occurs. CPS also states SWs continue to receive training about the PHN resources available to them when they are hired.

2016 Recommendation #2

Assign a PHN to every case that meets criteria, utilizing on-call, contract or registry nurses to fill the gaps as needed.

2017 Update for Recommendation #2

As of June 2018, CPS reports that SWs who have children involved in ER investigations and ongoing cases consult with PHNs as needed. CPS also has a Medical Review Team that provides consultation on services needed.

2016 Recommendation #3

Develop the resources to allow PHNs to follow high-risk medical children after the cases are closed with CPS. Currently, PHN services to child/family cease once the CPS case closes.

2017 Update for Recommendation #3

As of June 2018, CPS reports there are no current resources in place to allow PHNs to follow high-risk medical children after their CPS case has been closed. It cites WIC 16501.3, indicating only minor and non-minor dependents in foster care meet the criteria for public health nursing through child welfare

services and state that any additional PHN follow-up would need to be provided through another source of funding.

After cases have been closed, CPS PHNs have no authority to continue seeing high-risk medical children. CPS Oversight Committee would like to see some exploration of how this vulnerable population can continue receiving PHN services after the CPS case has been closed, in order to support families formerly involved with CPS, which may prevent future recidivism.

2016 Recommendation #4
Fully staff the Child Abuse Bureaus of local law enforcement agencies.

2017 Update for Recommendation #4
CPS Oversight Committee is conducting follow-up in 2018 to determine the number of child abuse reports and cases local law enforcement agencies are handling and how they respond to the reports. The committee will report findings in its next report.

2016 Recommendation #5
Provide additional mandated reporter training for DHA staff.

2017 Update for Recommendation #5
As of June 2018, DHA reports it has trained over 900 DHA staff members in Mandated Reporter Training. DHA states the individuals trained are the staff who work in the DHA open lobby locations that have face-to-face contact with the public and that new employees who go through Induction Training, held through DHA's Staff Development Office, also receive mandated reporter training as part of the curriculum.

The Oversight Committee wishes to acknowledge the collaboration between DHA and CPS with regard to reporting suspected child abuse and encourages continuation of mandated reporter training on a regular basis to DHA staff, so that they may remain up-to-date on mandated reporting laws and the staff's duty to report.

2016 Recommendation #6
Establish a Blue Ribbon Panel made up of members from Law Enforcement, Human Services agencies, such as Division of Behavioral Health Services and CPS, District Attorney's Office, Probation, hospital systems, health plans, California Children's Service (CCS), Alta Regional Center, and community-based organizations [such as WEAVE, the Family Resource Centers, and Head Start] *to address better collaboration and cultural competency, identify gaps, and offer solutions* [that may prevent child maltreatment and deaths]. *This panel would mirror a similar panel approved by the BOS addressing the disproportional rate of deaths among African American children.*

2017 Update for Recommendation #6
CPS Oversight Committee supports and will send representatives to participate in the Child Death Review Team's (CDRT) Child Abuse and Neglect (CAN) Homicide Review Subcommittee, which was a CDRT recommendation in its 2015 Annual Report. The CAN Homicide Review Subcommittee will be a diverse, multi-disciplinary committee comprised of members of the CDRT, policy leaders, representatives from county agencies, law enforcement, Coroner, City of Sacramento, representatives from hospital systems, and community non-profit stakeholders. The purpose of this subcommittee's work is to identify trends, risk factors, patterns across the cases, and categorize opportunities to identify and intervene in

intergenerational cycles of violence.[4] The subcommittee will develop a set of evidence-based recommendations that lay the foundation for a comprehensive countywide strategy to improve policy, systems, and services to end child maltreatment in our county. This subcommittee is projected to convene and begin work starting late fall or early winter of 2018.

2016 Recommendation #7

[We ask that the] Board of Supervisors request that CPS ensure that stronger drug and alcohol policies are put in place, that CPS workers have the resources needed to evaluate caretaker substance abuse (training, ready access to testing, consultative support, etc.), and that caretaker substance abuse is elevated to a higher priority when formulating the Safety Plans.

2017 Update for Recommendation #7

This recommendation remains an ongoing concern for the CPS Oversight Committee. According to the CDRT 2015 Annual Report, in 2015, 38 percent (48 of 126) of all child deaths had a known history of illegal drug use or alcohol abuse in the child's family. Thirteen percent (16 of 126) of deaths involved illegal drugs or alcohol at the time of death.[5] These statistics include marijuana, which was not legal at the time of the report. It should also be noted that among the *Sacramento County* child decedents who had a family history of illegal drug use (39 of 126, or 31 percent), the most commonly used drug was marijuana, which was present in 51 percent (20 of 39) of families involving illegal drug use.[6]

2016 Recommendation # 8

All dependents of CPS have the same level of intervention/attention that is being afforded to the Commercially Sexually Exploited Children (CSEC) population.

2017 Update for Recommendation #8

CPS Oversight Committee feels this recommendation is still important but understands that different children require different levels of support. The committee applauds the County for its CSEC program, hopes that a collaborative model like this will ultimately extend to all children suffering from child abuse and neglect, and will continue to advocate for this.

2016 Recommendations #9 & 10

CPS completes its work on Policies and Procedures and submits a timeline to the CPS Oversight Committee. Make P&Ps available via mobile devices and create the ability for staff to participate in online interactive trainings.

2017 Update to Recommendations #9 & 10

As of January 2018, CPS reports that P&Ps continue to be written or updated, vetted through stakeholder groups, and many are in the approval process. CPS states that of the 9,000 P&P documents reviewed, 156 were identified as currently relevant. Furthermore, it states 25 percent have been completed, approved, and posted to the website for SW access from the field and that the website is fully implemented. CPS projects that it will take approximately 1.5 to 2 years (by around the year 2020) to complete, approve, and upload all P&Ps to the website. The committee acknowledges the progress CPS has made in this area and will continue to follow this progress.

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[4] Sacramento County Child Death Review Team. (2017). *Sacramento County Child Death Review Team & Fetal Infant Mortality Review Annual Report 2015* (p. xi). Sacramento, CA: The Child Abuse Prevention Center.

[5] Sacramento County Child Death Review Team. (2017). *Sacramento County Child Death Review Team & Fetal Infant Mortality Review Annual Report 2015* (p. 33). Sacramento, CA: The Child Abuse Prevention Center.

[6] *id.*

2016 Recommendation #11
CPS continues to focus on domestic violence and progressive intervention.

2017 Update to Recommendation #11
As of June 2018, CPS reports it is in the process of completing a MOU to have two CPS SWs outstationed at A Community For Peace (a domestic violence family resource center) to continue efforts in improving outcomes for children exposed to domestic violence. CPS also reports it continues to partner with other local domestic violence agencies, such as WEAVE (Women Escaping A Violent Environment) and My Sister's House, to address the needs, safety and emotional well-being of children exposed to domestic violence. Additionally, CPS states it is in the early stages of planning a pilot program in CPS Intake, which will include teaming with a Domestic Violence Advocate to assist in improving its assessment of domestic violence referrals.

Domestic violence continues to be a concern of the Critical Incidents Subcommittee in its review of cases. According to the CDRT 2015 Annual Report, in 2015, 17 percent (22 of 126) of all child deaths had a known history of domestic violence in the child's family.[7]

2016 Recommendation #12
Continue to refine improvements within the CPS Call Center by decreasing wait times, consistent use of SDM hotline tools, and reviewing "evaluated out" dispositions.

2017 Update to Recommendation #12
As of January 2018, CPS reports that the CPS Call Center data has improved significantly. The addition of new staff and shifting staffing to meet the need during the busiest times has resulted in decreased wait times. Caller menus have been streamlined and are more caller-friendly. The committee recognizes the strides that have been made in improving the caller experience and will follow the continued improvements of the CPS Call Center.

V. Oversight Committee Recommendations

As a result of the observations documented in this report, the Oversight Committee recommends the following:

1. **Ensure SWs receive ongoing training on critical thinking to assist them in their investigation of child abuse, neglect, and/or death of children.**
2. **In assessing parents and family situations for neglect and/or abuse, based on our review, continued emphasis should be placed on the safety and well-being of children, not solely reliant on the unverified statements of the parents.**
3. **Ensure SWs are trained on ascertaining the medical needs of children and include PHNs in the evaluation process.**
4. **Ensure SWs are adequately trained to assess the impact of parental drug use, including marijuana, on children in the home; and that marijuana (and other legal drug) use is considered when formulating Safety Plans.**
5. **We ask that the Board of Supervisors request that CPS ensure that stronger drug and alcohol policies are put in place, that CPS workers have the resources needed to evaluate caretaker**

[7] Sacramento County Child Death Review Team. (2017). *Sacramento County Child Death Review Team & Fetal Infant Mortality Review Annual Report 2015* (p. 36). Sacramento, CA: The Child Abuse Prevention Center.

substance abuse (training, ready access to testing, consultative support, etc.), and that caretaker substance abuse is elevated to a higher priority when formulating Safety Plans.
(Continued recommendation from previous year)

6. **Evaluate and reduce caseloads to be consistent with best practices, conforming to the Child Welfare League of America (CWLA) Caseload Standards, which suggest caseloads of no more than 12 per worker[8]. This may necessitate adding more SWs to the CPS workforce.** (Currently the average caseload for Sacramento County Permanency SWs is 22. The average assignment of new investigations for Emergency Response SWs is 17 per month, which is in addition to cases still open from previous months for investigations, engagements with family, or referrals for services.)
7. **Ensure Emergency Response SWs verify parent participation with service providers before closing a referral.**
8. **Increase communication between SWs and community providers to ensure collaboration regarding children served by multiple systems.**
9. **Increase the number of PHNs available to SWs working in the Emergency Response division.** *(Continued recommendation from previous year)*

VI. 2018 Work Plan

- Review critical Child Protective Services cases
- Conduct research on organizations and operational units within the Child Welfare System
- Collaborate with the Child Death Review Team in the review of Child Abuse and Neglect homicides
- Review child abuse report case levels of local law enforcement agencies

[8] California Welfare League of America. (2012). *Direct Service Workers' Recommendations for Child Welfare Financing and System Reform* (p.5). Washington, D.C.: CWLA

Appendix A: CPS Oversight Committee Membership

Current Members:

Michael J. Baldwin
Director
Child Abuse Prevention Center

Michele Bell, MA
Permanency Supervisor, CPS
Department of Child, Family and Adult Services

Jane Claar, MSC, PPS
Coordinator, Child Welfare Attendance
Twin Rivers Unified School District

Sister Jeanne Felion, SSS
Executive Director
Stanford Settlement Neighborhood Center

Jaclyn Hobbs, BA
Emergency Response Social Worker, CPS
Department of Child, Family and Adult Services

Maynard A. Johnston, MD, FAAP
Retired Pediatrician

Sergeant Tom Koontz
Child Abuse Bureau
Sacramento Sheriff's Department

Dr. Virginia E. Maulfair
Volunteer
Sacramento Court Appointed Special Advocates

Chris Ore
Supervising Deputy District Attorney,
Special Assault and Child Abuse Unit
Sacramento District Attorney's Office

Sharon Rea Zone, LCSW
Infant Mental Health Program Manager, U.C.
Davis C.A.A.R.E. Center
U.C. Davis Children's Hospital

Elizabeth Uda
Program Officer, Head Start Program
Sacramento Employment and Training Agency
(SETA)

Previous Members in 2017:

Roy Alexander, LCSW
Chief Executive Officer
Sacramento Children's Home

Joni Edison, MSW
Retired Program Manager, Foster Care
Eligibility
Department of Human Assistance

Sergeant Ryan Johnson
Child Abuse Bureau
Sacramento Sheriff's Department

Sergeant Tony Saika
Child Abuse Bureau
Sacramento Sheriff's Department

Christina Solomon, BSW
Emergency Response Social Worker, CPS
Department of Child, Family and Adult Service

Appendix B: Acronyms and Abbreviations

(Includes references from previous years' reports)

ACFP – A Community for Peace

AOD – Alcohol and Other Drug

AWOL – Absent Without Leave

BEAR – Bridging Evidence Assessment & Resources

BHS – Behavioral Health Services

BOS – Board of Supervisors (Sacramento County)

CAN – Child Abuse and Neglect

CASA – Court Appointed Special Advocates

CCIC – Critical Case Investigation Committee

CCR – Continuum of Care Reform

CCS – California Children's Services

CDRT – Child Death Review Team

CDSS – California Department of Social Services

CFSR – Child and Family Services Review

CFT – Child and Family Review Team

CHDP – Child Health and Disability Prevention

CHPD – Citrus Heights Police Department

CI – Critical Incidents

CIL – Community Incubator Lead

CPS – Child Protective Services (Division)

QIC – Quality Improvement Committee

CSEC – Commercially Sexually Exploited Children

CWS/CMS – Child Welfare Services/Case Management System

CYPM – Crossover Youth Practice Model

DCFAS – Department of Child, Family, and Adult Services

DHA – Department of Human Assistance

DHHS – Department of Health and Human Services

DTECH – Department of Technology (Sacramento County)

DV – Domestic Violence

EFC – Extended Foster Care (California AB 12)

EO – Evaluated Out

EPY – Expectant and Parenting Youth

ER – Emergency Response

FFA – Foster Family Agency

FTE – Full Time Equivalent

H4K – Hearts for Kids

ILP – Independent Living Program

IS – Informal Supervision

LE – Law Enforcement

MDT – Multidisciplinary Teams

NMD – Non-minor Dependent

PCP – Primary Care Physician

PD – Police Department

PH – Public Health

PHN – Public Health Nurse

P&P – Policy and Procedure

QIC – Quality Improvement Committee

RAACD – Reduction of African American Child Deaths

RDA – Resource Development Associates

SB – Senate Bill

SCAN – Sacramento Child Abuse and Neglect (Team)

SETA – Sacramento Employment and Training Agency

SSF – Sacramento Steps Forward

SHRA – Sacramento Housing Redevelopment Agency

SOP – Safety Organized Practice

STRTC – Short Term Residential Treatment Centers

SW – Social Worker

TAY – Transition Age Youth

TDM – Team Decision Making

VOA – Volunteers of America