Child Protective Systems Oversight Committee

Annual Report 2018

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 relate 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 Department of Child, Family and Adult Services (DCFAS), especially Michelle Callejas, Melissa Lloyd, 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 this department, 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 wellbeing 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 the Department of Health and Human Services (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 to 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 committee; it is responsible for performing community review of critical CPS 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 Children's Coalition approves this report and the Oversight Committee presents it to the BOS annually.

The Oversight Committee is not limited to oversight of the County's CPS Division. It may choose to 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 confidentiality laws. The Juvenile Court order allows access only to 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 2018

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 2017 Annual Report, the Board of Supervisors (BOS) allocated resources to address needs identified by the Oversight Committee. CPS used these resources to create and fill new Social Worker (SW) positions in its Emergency Response and Informal Supervision units; according to CPS, this contributed to a decrease in SW caseloads and allowed SWs to provide a more intensive focus on the families assigned to them. The Oversight Committee has observed progress in these areas and wishes to thank the BOS for its support.

II. 2018 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. *(Link to meeting minutes and handouts: http://www.dcfas.saccounty.net/Admin/childrenscoalition/Pages/ChildrensCoalition_Home.aspx)*

Beginning in 2018, the CPS Oversight Committee embarked on a project to:

1. learn how Sacramento County Law Enforcement (LE) agencies respond to reports of suspected child abuse;
2. learn about average case levels in specific types of child abuse cases;
3. learn about staffing levels of LE agencies;
4. share thoughts and ideas around suspected child abuse reporting and the opportunities for collaboration between agencies charged with child protection; and
5. learn of ways the committee can assist LE agencies in their child protection efforts and/or advocate for their needs.

The committee conducted listening sessions with Galt and Folsom Police Departments about how each of their agencies treat Suspected Child Abuse (SCAR) reports, how the agency assigns cases for investigation, and how they classify and track their data. The agencies also shared some background about their staff make-up and average caseloads for detectives. The committee will invite Sacramento Sheriff's Department and City of Sacramento, Citrus Heights, and Elk Grove Police Departments to future meetings. The committee will share its learnings in its 2019 Annual Report to the Board of Supervisors, with recommendations on how the Board and the community can support LE agencies' child protection efforts.

The committee also received a CPS Division update from CPS Deputy Director Melissa Lloyd. The following summarizes the Q&A session conducted by the committee. When asked about Social Worker (SW) trainings, CPS shared that most trainings are mandatory for SWs and Supervisors, with the exception of specialized trainings for more skilled practitioners, such as trainings pertaining to sexual exploitation. CPS conducts some trainings in-house, such as those on policies and procedures and program-specific issues. Outside organizations, such as the UC Davis Northern California Children and Family Services Training Academy, conduct some trainings, and online

training is available, as well. UC Davis Extension offers an extensive training that addresses substance abuse and what to look for in the home. A retired law enforcement officer who specialized in this area teaches this training. In addition, a training about conducting assessments when parents/caregivers have marijuana cards is currently in development. The goal is to have this training held for all programs in CPS.

CPS maintains individual training records and strives for 100 percent attendance rate for mandatory trainings. A Workforce Development Unit tracks employee training attendance and engages employees (and their supervisors, if need be) in scheduling and attending required trainings. If, for some reason, an employee needs to leave in the middle of the training, they are required to take the training again. Generally, staff value and seek the offered trainings; they tend only to miss when a pressing matter arises. Supervisors have regular one-to-one meetings with SWs to support them and discuss performance-related issues. Supervisors will coach SWs in areas of deficiency and may ask the SW to attend a training again, if warranted.

With regard to Supervisor training, Supervisors attend the same trainings as SWs for practice-related topics – including issue around domestic violence, which are part of the new hire cohort trainings. Voluntary trainings are offered for practitioners that are more skilled. Supervisors also attend human resource-related trainings for supervisory functions. Supervisors participate in one-to-one meetings with Program Managers to support the Supervisor and receive feedback on performance, and have meetings/trainings with peers.

When asked about the long-term plan for reducing SW caseloads, CPS shared that caseloads are slowly decreasing in the Emergency Response (ER) division. This is, in part, due to receiving and filling new positions approved in the FY18/19 budget. The ER division is in the process of re-organizing, which will help supervisor span of control by reducing the ratio of Supervisors to SWs to a 5:1 or 6:1 ratio (which is the recommended ratio by Child Welfare League of America). CPS' goal is to get to 65 percent of SW availability (previously at 50 percent). The first two quarters of FY18/19 had shown progress towards meeting this goal.

CPS also shared that its Informal Supervision division also received new positions approved in the FY18/19 budget. Caseloads in this division are maintaining, allowing the SWs to provide a more intensive focus on the families assigned to them. This program reduces the numbers of children placed in foster care by providing families with supports and intensive services. In Permanency and Court Services, caseloads remain stable and staffing remains steady. When asked about its strategy of shifting some administrative work away from SWs to free up their time, CPS shared that it offers SWs clerical support for data entry and that some are utilizing the support. For those reluctant to allow others to enter their notes, clerical staff are helping in other ways to reduce work. For example, they are setting up templates to make entering notes quick and easy. Clerical staff also assists with obtaining information for SWs ahead of time, which helps the investigative process.

The committee and CPS discussed other resources that assist SWs in conducting timely investigations and recommendations, such as a "SMART Page", which is a list of the most commonly used resources used by SWs when out in the field. SWs also have access to school district liaisons who assist them in locating school-age children, as well as a "Foster Focus" database maintained by Sacramento County Office of Education. In addition, other CPS staff assist SWs in gathering education information and help with IEPs.

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 regularly to review a subset[2] of

[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.

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 child protective systems partners may learn from to improve practice and avoid repeating mistakes of the past.

Representatives from the CI Subcommittee sit on the CPS Quality Improvement Committee that reviewed the cases described in this report. These internal reviews, facilitated by County CPS, focus on identifying CPS systemic issues that may have contributed to an environment of "missed opportunities" to intervene with families that subsequently experience a child fatality or near fatality related to maltreatment . This Quality Assurance (QA) Framework within the CPS organization was a recommendation of the CPS Oversight Committee in its 2012 Annual Report. CPS implemented this in 2013, when it received resources from the Board of Supervisors to build this framework. CPS designed this QA Framework according to guidance from a U.S. Administration for Children and Families' Continuous Quality Improvement memorandum describing five components essential to a quality assurance model for child welfare agencies. These components are: 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. Beginning in April of 2019, CPS has invited the entire CI Subcommittee to participate in these Quality Improvement Committee meetings.

Cases Reviewed in 2018

This report highlights the cases reviewed and observations of the CI Subcommittee in 2018. The CI Subcommittee reviewed five cases. As in the past, most of these cases had complicated social and family issues. The CI Subcommittee continues to see cases where key interventions, applied early on, may have prevented critical incidents.

The CI Subcommittee identified some common issues in its review of these five cases, including: family history of substance abuse, mental health concerns, and/or domestic violence; and SW lack of medical follow-up, not taking advantage of Public Health Nurse (PHN) availability, undervaluing collateral contacts, and lack of critical thinking. Two of the five cases involved medically fragile children.

These five cases show some of the same issues/concerns/errors stated in last year's report:

- Lack of critical thinking – not looking at the total picture, too narrow of a focus
- Not all medically fragile children were referred to PHNs
- Impacts of drug abuse, mental health issues, and domestic violence on the child's safety were understated regarding their importance
- Lack of follow-up to verify whether or not parents had completed recommended/required training or had taken advantage of offered referral services
- Lack of adequate Safety Plans

Additionally, we found that often not all adults involved in the child's life were interviewed to ensure they were suitable to be involved in the lives of these children. In some cases, this oversight led to adverse events.

CI Subcommittee New Recommendation

The law states that, for 10-day response, an attempt to contact the family should be done within 10 calendar days. Recognizing the underlying goal of this requirement is to begin the investigation within 10 days, we suggest that CPS conduct an analysis to determine how many investigations currently have an actual face-to-face communication within 10 calendar days. We further suggest that, in addition to this baseline performance measure, CPS conduct an in-depth analysis on those 10-day response referrals that do not have a face-to-face communication, with the goal of determining the barriers that might be impeding timely investigations.

The CI Subcommittee, again, wishes to acknowledge the important work that CPS Social Workers 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. CPS continues to strive, working as a true "learning organization." The CI Subcommittee acknowledges that CPS has become more open and transparent since the inception of the Oversight Committee. CI Subcommittee members, in working with CPS on its internal reviews, have noticed that CPS is working to critically assess its operations and develop a willingness to make changes and continually assess the effectiveness of any changes. This committee believes that this shift in the organization has been a direct result of the management style of its leaders.

IV. Oversight Committee Recommendations

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

1. Continue to ensure CPS Social Workers receive ongoing critical thinking training and supervisor coaching to ensure the information gained (especially from Case Discussion trainings) is applied in their investigations of child abuse, neglect, and/or death of children.
2. Continue to ensure that *all* CPS Social Workers are adequately trained to assess the impact of parental drug use (including marijuana and other legal drugs) on children in the home; and that supervisors provide coaching to ensure that drug use in the home environment is given appropriate weight in the Safety Plans.
3. In assessing parents and family situations for neglect and/or abuse, based on our review, *more* emphasis should be placed on interviewing *all* collateral contacts, and verifying their concerns, to ensure the safety and wellbeing of the children.
4. Continue to increase the number of Public Health Nurses available to Social Workers working in the CPS Emergency Response division.
5. Strengthen the partnership between CPS Social Workers and Public Health Nurses to ensure *all* identified medically fragile children receive a holistic evaluation.
6. CPS continue to evaluate and reduce caseloads to be consistent with best practices, conforming to the Child Welfare League of America (CWLA) Caseload Standards; and Board of Supervisors support adding more Social Workers to the CPS workforce, if CPS deems it necessary.
7. Conduct an analysis to: 1) determine how many CPS investigations currently have an actual face-to-face communication within 10 calendar days; and, 2) for the 10-day response referrals that did not have a face-to-face communication, identify (and learn from) the barriers that impeded timely investigations.
8. Continue to ensure Emergency Response Social Workers verify parent participation with service providers before closing a referral; and increase collaboration between CPS and these community providers to improve the flow of information and better support families that have had CPS involvement.
9. Board of Supervisors support the Sacramento Prevention Cabinet in its efforts to develop and implement a Sacramento Child Abuse Prevention Plan. *[see Appendix A, 2016 Recommendation #6 for more information]*

V. 2019 Work Plan

- Review critical Child Protective Services cases
- Conduct research on organizations and operational units within the Child Welfare System
- Collaborate with the Sacramento Prevention Cabinet in the development and implementation of a Sacramento Child Abuse Prevention Plan
- Review child abuse report case levels of local law enforcement agencies and learn of ways the committee can assist these agencies in their child protection efforts and/or advocate for their needs

Appendix A: Previous Oversight Committee Recommendations & Updates Received

The Oversight Committee received much of this information from DCFAS Director Michelle Callejas, CPS Deputy Director Melissa Lloyd, and members of the CPS organization.

2017 Recommendation #1
Ensure CPS Social Workers receive ongoing training on critical thinking to assist them in their investigation of child abuse, neglect, and/or death of children.

2018 Update for Recommendation #1
Critical thinking continues to be emphasized in training and supervision with all staff, as CPS understands the importance of an objective approach to the work and doing everything possible to ensure that decisions are logical, reasonable, and free from personal bias. CPS knows that critical thinking cannot be fostered utilizing a traditional classroom training approach and therefore, uses a multi-layered approach to develop and support ongoing critical thinking. This approach includes training and coaching on Safety Organized Practice (SOP); Structured Decision Making; case reviews and group discussions with SWs, supervisors and managers; the Quality Improvement Committee; and individual supervision between managers and supervisors and supervisors and social workers.

Safety Organized Practice is an approach that includes skill sets and tools to engage with children and families in order to gather more information regarding the safety and well-being of children. The tools also allow SWs to sort out the information to more clearly identify safety and risk issues. One example is the Safety Map, which is done with the family, often in a Child and Family Team (CFT) meeting. The CFT includes the parents, children (if age appropriate), mental health or other service providers, family members and any others that are willing to help support the family. The parents and children identify who they would like at the CFT meetings. The Safety Map addresses concerns (the incident or issues that brought the family to the attention of CPS), strengths of the family (how they have handled past difficulties, how they have kept their children safe, times when things were going well, etc.), worries about future safety of the children if nothing changes, and an action plan – what needs to happen next. This approach allows for clear and honest dialogue and the parents, social worker, and others in the room clearly understand the issue and what needs to happen in order for CPS to cease involvement with the family. The action plans are behaviorally-based versus service-based. In other words, the focus is on behaviors that need to change – behaviors that demonstrate the ability to keep the child safe. The services provided are geared toward helping the parents make the necessary changes, rather than just offering an array of services that, while instructional, may not address the behaviors.

The Safety Map is just one example of how SOP promotes an objective approach to gathering information and incorporates critical thinking throughout the work with the family. CPS provides many opportunities for SOP training and coaching for all levels of staff. In supporting this effort, CPS contracts with the University of California Davis' Northern Training Academy to provide SOP Coaches to train both managers and supervisors on SOP coaching. Additionally, to strengthen supervisor's coaching skills, CPS piloted a Supervisor Practicum in 2018. The Supervisor Practicum meets quarterly and includes management participation. The practicum was developed and facilitated collaboratively with the Casey Family Foundation. Supervisors are introduced to a supervisory framework that utilizes coaching to teach and reinforce skills in SOP Mapping, Child and Family teaming, building trust, enhancing critical thinking skills, and strengthening overall practice. The work done in the Supervisor Practicum has resulted in improved coaching skills and has raised supervisor's confidence in their ability to coach staff on utilization of SOP tools and fostering their critical thinking skills.

Another example of how CPS promotes critical thinking is the Quality Improvement Committee (QIC) and the small Quality Improvement Committee workgroup, known as the "Small QIC". The QIC reviews critical incidents looking at both the good work that was done, as well as areas where something may have been missed and/or where a different decision could have been made. The case reviews done at the QIC determine which cases are utilized in the "Case Discussion" trainings. The Case Discussion trainings are provided to all SWs, Supervisors and Managers and incorporate SOP Mapping to analyze the case, identify critical thinking errors and look for possible patterns regarding decision errors. The Case Discussions were developed based on a recommendation from the CPS Oversight Committee that stemmed from the concern the SWs weren't provided an opportunity to also analyze, discuss and learn from critical incidents. The feedback from staff has been very positive about this approach.

In an effort to move this work to the next level of critical thinking and to have a larger impact on our practice, QIC is researching and developing tools for Root Cause Analysis. The plan is to develop a means to use Root Cause Analysis to develop a clearer understanding of what caused the unwanted outcome and to use this to inform the training and/or actions needed to improve practice. In addition, members of the Oversight Committee have begun to regularly attend the monthly QIC meetings. The addition of their collective knowledge and feedback in this meeting will greatly benefit the work of CPS staff as the agency continues to infuse critical thinking into daily practice.

2017 Recommendation #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.

2018 Update for Recommendation #2

The SW's assessment for safety is not based solely upon one individual's unverified statement. In addition to Safety Mapping described above, SWs, when possible, interview family members separately to allow each family member to speak freely. SWs also interview collateral contacts, which can include extended family members, school staff and other service providers who have knowledge of the family. Additional information is obtained through case file reviews and criminal background checks. All of the information gathered during the investigation focuses on the safety and well-being of the child and is used to develop behaviorally-based service plans.

When discrepant information is found, the SW makes every effort to resolve the discrepancy by seeking clarification, asking more questions and obtaining information from collateral contacts. SWs complete the SDM Safety and Risk Assessments and discuss the investigations with their supervisors. If a safety concern is identified, a Safety Plan may be developed if at least one caregiver in the household has protective capacities and is willing to participate and take actions to protect the children. The Safety Plan is behaviorally based, is developed by meeting with the family and their support networks, and is a collaborative effort to address immediate child safety concerns. Safety goals are created with the family's input using their language and should include the child(ren)'s voice. A Safety Plan identifies the immediate and long-term actions that will keep the child safe from harm, includes a harm and danger statement, a safety goal, support networks and an action plan. The Safety Plan is monitored and remains active during the time that the referral is open or when a referral becomes a case and is transferred from Emergency Response to Permanency. The referral is not closed unless the safety threats to the children have been mitigated.

2017 Recommendation #3

Ensure CPS Social Workers are trained on ascertaining the medical needs of children and include PHNs in the evaluation process.

2018 Update for Recommendation #3
Child Protective Services places an emphasis on having PHNs available to social work staff as a resource. In Emergency Response, PHNs can visit families with an SW and/or after the SW to assist in determining the medical needs of children.

CPS has a specialized medical neglect investigation unit within Emergency Response, which has two Specialized Medical Neglect SWs and four non-Medical Neglect SWs. The Medical Neglect SWs respond to allegations of abuse or neglect that have a medical neglect component to them. The referrals assigned to these SWs are those for which a child's caregiver has not obtained adequate medical care or has not followed recommended medical treatment. Referrals related to medically fragile children where the abuse and/or neglect is not necessarily related to neglect are not assigned to medical neglect SWs.

When a referral with a medical neglect component is received and there is not a Medical Neglect SW available, the referral is assigned to a non-Medical Neglect SW within the Medical Neglect Investigation Unit. If SWs within the Medical Neglect Investigation Unit are not available, best efforts are made to assign the medical neglect referral within the region in which the Medical Neglect Investigation Unit is located and a PHN referral is made. The Medical Neglect Investigation Unit Supervisor maintains oversight of these referrals in these circumstances.

If there is a referral that cannot be assigned within the Medical Neglect Unit or bureau, the Medical Neglect Supervisor can be utilized for consultation. Medical neglect referrals assigned to a non-Medical Neglect SW must be reviewed by the Medical Review Team before the referral can be closed. The Medical Review Team includes representatives from CPS, Public Health, California Children's Services, and California Alta Regional Services.

Children who enter foster care with complex medical conditions, if known, will be assigned to a Medical Neglect SW. Currently, there is a designated Medical Neglect SW in Court Services as well as in the South, Central and North Regions of Permanency. Efforts are being made to identify and train a Medical Neglect SW in the East Region. In the meantime, supervisors and/or managers discuss the case and determine which Medical Neglect SW in another region can best support the family.

CPS also partners with California Children's Services (CCS) to ensure that medically fragile children receive proper care. A CCS/CPS liaison is available for consultation on an as-needed basis. The CCS/CPS liaison provides support by staffing cases, obtaining records, and identifying additional resources. The CCS/CPS liaison is also available to answer questions about CCS eligibility and medical concerns. Additionally, quarterly reports that link CCS clients to CPS clients are provided to CPS management to cross reference with the SW and supervisor assigned to the child's referral or case to ensure the SW and supervisor are aware the child has an open CCS case and that there is routine consultation with the assigned nurse from CCS to ensure proper services are being delivered to the child and caregiver.

2017 Recommendation #4
Ensure CPS Social Workers 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.

2018 Update for Recommendation #4
CPS takes seriously the issue of substance use/abuse as it relates to a caregiver's capacity to provide a safe environment for children. Curriculum on identifying substance abuse and assessing the effects on a parent's ability to provide care for their children is woven throughout the new SW induction training series provided by CPS, as well as the statewide Core 2.0 training for new SWs provided through the Regional Training Academies across the state.

Separately, UC Davis offered a two-part training called "Recognizing Drug Abuse in the Home." Part 1 of the training focused on methamphetamine and opioid abuse and Part 2 focused on the use and abuse of marijuana. The training provided participants with the ability to recognize behaviors that may be indicative of current drug use and/or manufacturing in the home. Staff were educated about various types of drug paraphernalia and manufacturing materials, use of critical decision-making skills for personal protection, and a better understanding of immediate welfare concerns of children found in drug-related environments. Participants also received a field guide that provides in-depth facts, pictures and scenarios to look for when they are out in the field or in client's homes.

This training is provided to all new SWs and, to-date, 632 CPS staff members, including Family Service Workers, Family Service Worker Supervisors, SWs, SW Supervisors, Program Specialists, and management have participated in the training. There is additional training provided by Sacramento County Behavioral Health Services and the STARS/Bridges program, our partner agency that provides services for clients involved in the Early Intervention Family Drug Court and the Dependency Drug Court.

If a SW discovers that the parents are using alcohol or drugs – whether they are legal or illegal – the SW assesses further to determine the impact of the use on their ability to provide a safe environment for the children. If it is determined that the substance use poses a safety threat but CPS assesses that the child can remain safely in the home, actions are taken to develop a robust Safety Plan that specifically addresses the substance use issue. This could include an alcohol and drug assessment, random drug testing, as well as unannounced home visits by the SW. If the use poses a serious threat and CPS assesses that the child cannot remain in the home safely, the child is removed.

2017 Recommendation #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 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.

2018 Update for Recommendation #5

As mentioned in the response to Recommendation 4, CPS has elevated the issue of caretaker substance abuse by partnering with UC Davis to provide the comprehensive, two-part training called "Recognizing Drug Abuse in the Home" and by incorporating an understanding of drug abuse into its general curriculum on child safety. As mentioned in previous responses to this and other substance abuse related recommendations, CPS provides ongoing training to SWs regarding the impact parental substance abuse can have on child safety and well-being. The policies and procedures regarding parental substance abuse currently in place in CPS are as strong as the law allows. CPS cannot require parents to submit to a drug test, however when a parent refuses to do so, SWs take that information into consideration as part of their overall safety assessment. The assessment specifically focuses on whether or not use/abuse of alcohol or drugs – whether legal or illegal – impacts the parent's ability to provide a safe environment for the child. Substance use is addressed in Safety Plans and the parent's compliance with the Safety Plan, including participation in services, is monitored. If a parent deviates from the plan, posing a safety threat to the child, CPS assesses to determine if a higher level intervention is needed, including removal of the child from the home.

2017 Recommendation #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. This may necessitate adding more Social Workers to the CPS workforce.

2018 Update for Recommendation #6
CPS has been working hard to reach an average monthly rate of 12 referrals per Emergency Response SW, consistent with the CWLA Caseload Standards. While we have seen some progress, meeting this goal is a struggle, in part due to demand.

Since 2015, the average monthly referrals per SW has dropped by one – from 19 in 2015 to 16 in 2018. From January through April of 2019, the rate is 13 per social worker.

2017 Recommendation #7
Ensure Emergency Response Social Workers verify parent participation with service providers before closing a referral.

2018 Update for Recommendation #7
When parents are referred to services in order to mitigate risk and safety issues that do not rise to the level of court intervention, CPS policy requires that SW verify parent participation with service providers prior to closing the referral.

SWs contact service providers via e-mail, phone, or fax to verify that the parents have completed training and/or accessed referred services. Parents can bring verification in the form of receipts, certificates, or agency letters to CPS, as well. Due to the limited amount of time an Emergency Response referral can remain open (up to 30 days after the first contact is made), the SW is often only able to verify enrollment in services, rather than completion of the services. Parents also are able to report that they have completed various services prior to CPS involvement (i.e. parenting classes). CPS can evaluate and confirm the completion of the services and assess the relevance of those services in relation to the family's circumstances. This practice is completed when it is deemed necessary that the family engage in community-based services in order to prevent possible further involvement with CPS. These instances could include investigations that have High or Very High Structured Decision Making Risk Assessments. Referrals that result in a Very High Risk Assessment require that a program manager review the referral prior to closure if the referral does not result in the transition to a case. Providers of services are mandated reporters and will report if parents discontinue services and there is a concern about abuse and/or neglect.

2017 Recommendation # 8
Increase communication between Social Workers and community providers to ensure collaboration regarding children served by multiple systems.

2018 Update for Recommendation #8
Collaboration with system and community partners is a core value of DCFAS as families are often involved with other child and family serving agencies. SWs regularly communicate with service providers, county agencies, and collateral contacts during the course of their investigation and in their ongoing case management work. SWs are required to communicate and coordinate services and care with others that are working with the child and family. Effective engagement with community partners is essential in supporting youth and families.

Communication and collaboration occurs in a multitude of practice approaches, including, but not limited to, Child and Family Team Meetings (CFTs), Multi-Disciplinary Team Meetings (MDTs), Joint Assessment Meetings (between CPS and Probation), co-location of SWs in schools and law enforcement jurisdictions, co-location of SWs in the Community Incubator Leads that are part of the Black Child Legacy Campaign, partnering with the CPS Cultural Brokers, and in ongoing cross-systems meetings and trainings.

The Black Child Legacy Campaign has strengthened CPS' collaboration with agencies that serve predominantly African American families and has led to more resources that can help families involved with CPS. The CPS Cultural Brokers are strong partners and work with our SWs, support our families in achieving their goals, and

ensure their voices are included in any plan development and decision-making. Collaboration and access to the expanse of diverse community partners helps SWs develop behaviorally-based case plans and Safety Plans that are culturally relevant and build on family strengths.

Specialized populations have led to further partnerships and collaboration in serving children, youth, and families. For example, a host of community and system partners (CPS, Probation, Behavioral Health Services, Juvenile Court, District Attorney, Public Defender, Sacramento County Office of Education, WEAVE, UCD Medical Center CAARE Team, Children's Law Center, and others) have worked together since 2014 and developed protocols to reduce the number of youth that cross over from child welfare to juvenile justice. Many of those same partners developed another set of protocols to identify and serve children and youth that are victims of sexual exploitation. SWs communicate and coordinate care with Probation, Behavioral Health providers, law enforcement officers, and community-based providers, as we strengthen our collective efforts to address vulnerable children and youth in our community. At a recent CSEC (Commercially Sexually Exploited Children) Steering Committee meeting, which includes the partners mentioned above, the Assistant Chief Deputy District Attorney noted that this partnership has greatly improved communication and collaboration with all partners involved and has positively impacted how we serve our youth in the community and in the courtroom. Several other agencies and providers at the meeting agreed.

Collaboration, communication, and coordination of care is vital to effectively serving children and families in our community. This collaborative approach allows each partner and/or system to leverage the strengths of each agency involved. It also brings child and family serving entities together to share responsibility and accountability for children and families.

2017 Recommendation #9
Increase the number of Public Health Nurses available to Social Workers working in the Emergency Response division.

2018 Update to Recommendation #9

It is difficult to determine if we have "adequate" PHN support, as PHNs in Emergency Response are not utilized for all opened referrals, but rather are focused on families with children who have medical complexities. This is something that CPS management will continue to assess.

CPS is very grateful for the support PHNs do provide and they are valuable partners in the work. They are supportive to the staff and are accessible, responsive, and flexible. They provide training to our staff and participate in Child and Family Team meetings, Medical Review Team meetings and case discussions at unit meetings. They accompany Emergency Response SWs on immediate response referrals with very short notice and work with families to help them navigate the medical system.

PHNs are also available as needed to consult with Intake SWs when medical neglect concerns are reported at the Hotline.

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.*

2018 Update for this Recommendation

Last year, the Oversight Committee reported that it would support and participate on 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 recommended CAN Homicide Review Subcommittee was described as 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 would be to identify trends, risk factors, patterns across the cases, and categorize opportunities to identify and intervene in intergenerational cycles of violence.[3] The subcommittee would 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 was initially projected to convene and begin work starting late fall or early winter of 2018. However, due to staffing and other priorities, this never was realized.

In May of 2019, the Oversight committee received an update from the directors of DCFAS and the Child Abuse Prevention Council (CAPC) that a Sacramento Prevention Cabinet was recently formed to strengthen the countywide public-private partnership for primary and secondary prevention of child abuse and neglect. Currently, the cabinet includes executive leaders from the following agencies/organizations: Department of Child, Family and Adult Services/Child Protective Services Division, Child Abuse Prevention Council, Department of Health Services/Public Health and Behavioral Health Divisions, Department of Human Assistance, First 5 Sacramento, Probation Department, Sacramento County Office of Education, Kaiser Permanente, Sierra Health Foundation, Strategies 2.0, and California State Department of Social Services/Office of Child Abuse Prevention. The cabinet will recruit more members to represent all four hospital systems and key non-profit organizations. This cabinet will assume the work planned for the CAN Homicide Review Subcommittee of the CDRT.

The cabinet's short-term objective is to develop a countywide child abuse prevention plan. The projection to achieve this is by spring of 2020. The long-term objective is to commit to an ongoing, collaborative implementation process, informed by solid data, with clear action steps, community stakeholder participation, project evaluation, and continuous improvement. The Oversight Committee was invited to participate in the workgroups formed by this cabinet, related to data review (including CAN homicides and critical incidents), cross-systems policies, and community outreach. The cabinet has applied for a grant from the U.S. Department of Justice to fund this effort for the next three years. They hope to receive notice of an award within the next two months.

[3] 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.

Appendix B: CPS Oversight Committee Membership

Current Members:

Michael J. Baldwin
Director
Child Abuse Prevention Center

Robin Blanks-Guster
Retired Nurse
Substitute Para-educator
Elk Grove Unified School District

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

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

Robyn Peace
Pediatric Licensed Clinical Social Worker
U.C. Davis Medical Center

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

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

Sergeant James Wilcox
Child Abuse Bureau
Sacramento Sheriff's Department

Previous Members in 2018:

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

Sergeant Ryan Johnson
Child Abuse Bureau
Sacramento Sheriff's Department

Sergeant Tom Koontz
Child Abuse Bureau
Sacramento Sheriff's Department

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

Appendix C: 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

CAPC – Child Abuse Prevention Council

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

QA – Quality Assurance

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