



Fighting for Children's Rights

**FCF Remarks to the
Tri-County Legislative Delegation Town
Hall Meeting on DCF Issues
August 20, 2013**

- 1. Increase Transparency: Require Real Time – Online Reporting of Child Abuse and Neglect Deaths and Near Fatalities and Public Reporting of Lawsuit Settlements.**
 - Child deaths and near fatalities should not be a secret - We shouldn't have to rely on local media reports as our source of information.
 - We have a system of community based care, yet the community cannot analyze the problem or help with solutions when the child's death / injuries are kept secret.
 - Arkansas provides a model for real-time reporting of all deaths and near fatalities on a website accessible by all. <https://ardhs.sharepointsite.net/CFN/default.aspx>
 - The resolution of lawsuits against community providers for death and serious injury should also be made available for public scrutiny.
 - Draft bill language is attached.

- 2. Restore / Improve Oversight and Accountability to both the Department and the Community Based Care Lead Agencies.**
 - a. The Legislature must ensure that DCF has adequate funds to fulfill its oversight responsibilities. DCF must restore create a robust quality assurance/quality improvement process and employ enough contract management and the district and central office staff to do the job.
 - In the past 5 years, DCF quality assurance staff has been reduced by 72%.¹ The Department's quality assurance/quality improvement process and contract oversight of the provision of child welfare services has been decimated.
 - When DCF saved money by cutting positions, it shifted a substantial portion of quality assurance responsibilities to the CBC Lead Agencies themselves. The results of these cutbacks are less than stellar:
 - The number of CPI cases subjected to quality assurance review was substantially cut back.
 - Lead Agencies conduct their own quality assurance reviews.
 - Lead Agencies are required to obtain an independent 3d party review, but few appear to have fulfilled the spirit of that requirement. Several CBCs contracted with each other to perform that review. (Our Kids/Children's Network of Southwest Florida; CBC of Central Florida/Community Partnership for Children; Family Support Services of N. Florida/Community Partnership for Children; Kids First Florida (Clay County)/Family Integrity Program (St. John's County).

 - b. "Community Based Care" necessarily requires there be community oversight of the Lead Agencies. The Legislature should commission an independent evaluation to

¹ DCF memo of July 29, 2013 reviewing changes in Quality Assurance from 2008-2013.

determine if the statutory mechanisms put in place to promote community oversight of Community Based Care Lead Agencies are achieving that goal

- The statute establishing Community Alliances (FS. 20.19(4)(a)) requires that DCF establish a community alliance in each county to provide a focal point for community participation and governance of community-based services.
- There is a wide divergence in the functionality of Community Alliances.
- Each community should have an active and engaged Community Alliance. Each Community Alliance board should have specific training on what to look for and how to provide oversight of the service providers in their community who are receiving state funding.
- CBC Lead Agency Boards: Board members have a fiduciary duty to ensure that the organization that they govern is using their resources wisely and achieving the desired outcomes. In the case of Community Based Provider Boards of Directors, that duty should be heightened in the regard that they are responsible for the use of state dollars and more important, are responsible for the safety and well-being of the children in their care.
- The CBC Lead Agency Boards should have adequate and appropriate training in order to be highly effective in their oversight of the activities of the lead agencies.
 - CBC Boards of Directors are often a list of the “who’s who” in the community. They are good, caring people who are serving as volunteers on the boards of the private companies who are providing all of Florida’s child welfare services.
 - Yet, many have no experience or knowledge of the child welfare system, and therefore do not know what to look for internally to see that the CBC is doing the best job.
 - The state should require annual mandatory training for CBC Lead Agency Boards.

3. “Child Protection Investigation Transformation” should be Examined and Revised Before Additional Time and Money is Spent on Implementation.

- We support the over-arching concept of improving child protective investigations by gathering more data and making individualized determinations about each family.
- We have serious concerns about the details of how Transformation is being implemented:
 - The minutes of the Child Protection Transformation Advisory Board of March 22, 2013 reflect that the former Secretary declared that “Child Protection Transformation and the Florida Safety Decision Making Methodology Implementation was in full force . . .” Roll out of training began on July 1, 2013, BUT
 - The training uses an instrument that has questionable validity.
 - It is not clear that the training is effective. Will it achieve inter-rater reliability? (All persons being trained will apply the tools in a consistent manner to reach the same conclusion in a specific set of facts.)
 - DCF’s Administrative Rules implementing Transformation are not in place.
 - DCF did not hold any workshops on these important rule changes.

- DCF issued its proposed rule July 12, 2013, eleven days **after** the statewide roll out of Transformation.
- There is no guidance in the proposed rules for how investigators are supposed to work during the transition between the current process and the new process. This process is anticipated to take at least one year.
- On August 8th, DCF held a hearing in response to our request, but failed to answer any of the questions we posed as required by FS §120.54(3)(c). We still await DCF's response.
- There are several extremely troubling aspects to the proposed rules – including the elimination of high-risk reviews, the elimination of the section on child-on-child sexual abuse, and the detailed requirements for institutional investigations.
- **Florida must pay attention to the lessons from our past – not discard them.** The segments of the rule that are proposed to be removed (high-risk reviews for calls concerning very young children; specific guidelines on investigating child-on-child sexual abuse, and relevant scrutiny for institutional investigations) were previously placed in the Rule after careful consideration and as solutions to past problems. The Legislature should hold DCF to account for the status of implementing the recommendations in the reports of its own commissions and grand jury reports: E.g. Gabriel Myers Workgroup;

4. **Keeping Children Safely at Home Requires the State to Invest in Community Resources.**

- Most children who come to the attention of the Department can remain safely at home if we provide the right services at the right time to their families. If those services are not available, or if the state does not engage the families in the right services, children who are left at home will needlessly suffer and some will die. **When children found to be at moderate or high risk of future harm are left in their home, DCF should not be driven to close those cases quickly. CBCs must be appropriately engaged with families of those children and accountable for following through on needed services.**
- The success of Child Protection Transformation necessarily relies on the availability of community resources. Yet no additional assistance was offered to help communities develop needed resources. Instead this appears to be another in a series of unfunded mandates –where DCF shifts the responsibility but not the resources to the community.
- If the State is serious about protecting children from harm, it must invest in the programs that work: Healthy Start, Healthy Families, School Readiness (subsidized child care), Early Steps, APD services, along with the substance abuse, mental health and domestic violence services.