

Child Protection Transformation Project Design Session
Teamwork with External Partners
Advance Reading
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Summary of the CPI Need, Coming From Phase I

At the June summit of Florida's identified "CPI Champions," they were asked about the role of key partners in their most successful investigations work. Key partners discussed were law enforcement, Child Protection Teams, substance abuse, mental health and domestic violence. The common thread through all of these discussions was an understanding that "we are all on the same team" and working on the same goal: to help and safely maintain and preserve children with their own families whenever possible. The attributes of good communication with partners include good communication and immediate, easy access to each other. Our best work occurs when we succeed in collaborative discussion and planning as to specific child and family and have clear understanding as to our respective roles and responsibilities.

Current Situation

The list of potential external partners that CPIs might need to work with any one case can be extensive. There is a joint response to the child's home when a potential crime has been committed or the assistance of law enforcement is needed for safety concerns. Law enforcement must take a lead in conducting a criminal investigation; the CPI must take the lead in determining if a child is in danger and needs appropriate safety interventions. How interviews are handled and how evidence is gathered must be carefully coordinated. When physical injuries or medical concerns exist around alleged maltreatment the child must be seen by a Child Protection Team (CPT). At times, a newborn or child is in a hospital setting and the hospital professionals need to be kept in the communication loop by the CPI. The CPI should accompany the child and family to the CPT for any on-site exams and evaluations required and to discuss the findings. If there is a concomitant criminal investigation, all three entities need to coordinate their work.

When substance abuse is suspected, the expertise of a substance abuse professional is often required to conduct an assessment to determine if the caregiver has a drug dependency. When domestic violence is a factor, there is often a need to enlist a domestic violence advocate to assist the parent who is also a

target of the person perpetrating the family violence. When there is a need for possible court action to ensure that parents are held accountable for follow-through on safety-related actions, or when children need to be removed, the CPI will need to call on the internal department partner, Children's Legal Services (CLS). In the more serious cases, the CPI will request early services provision by the Community Based Care. All of the persons involved need to be coordinated in developing an understanding of the current situation and actions required. The CPI is at the hub of a team of family members and professionals who all have a different part to play in a complex, rapidly unfolding family crises. The CPI has the constant challenge of organizing all of these persons into a well-functioning team that is up to date with the current situation, respective roles and expectations, and achieves consensus on next steps and actions needed.

With the Department's current 35% turnover rate in child protective investigations it is extremely challenging to sustain an adequately informed workforce and ensure that they are appropriately collaborating with their partners. High turnover precludes the development of working relationships that can successfully handle complex child welfare cases and teamwork with multiple system partners. It should also be noted that there has been a trend over the last few years of CPIs working outside of an office environment; frequently referred to as "hoteling." Although there are some cost and time management advantages to this approach, there may be some significant down sides as well. For instance, not having an office environment with your peers or not being co-located with an external partner could make it more difficult to build on and nurture effective working relationships.

Phase II Work and Findings

Over the last three months the external partners team identified several critical areas of importance specific to working with external partners and particularly advancing family centered practice. Their work and findings are summarized in four topic papers: Attachment 1, Teamwork with Law Enforcement; Attachment 2, Teamwork with Child Protection Teams; Attachment 3, Teamwork in Child Welfare Cases involving Domestic Violence; Attachment 4, Teamwork in Child Welfare Cases involving Substance Abuse. A partial summary of findings is presented below:

Finding # 1, Law Enforcement

There are 241 Memorandums of Understanding (MOU) between the Department and local law enforcement agencies throughout the state. The MOUs vary in purpose, authority, and definition, and describe very different policies and procedures. They range in length from as few as seven (7) pages to as many as 28 pages. Overall, CPI and local law enforcement work well together when law enforcement is appropriately notified and requested to assist. There are concerns over resource availability, time involvement and documentation requirements. In addition, there are sometimes conflicts between agencies and responders when the alleged abuse, neglect or abandonment occurred in one county's jurisdiction, but the child is in another jurisdiction (in hospital or otherwise). There is also noted discrepancy as to the level of implementation and adherence to MOU protocols. Some of the MOUs included good practices while others are written at a very high level without details.

Finding # 2, Child Protection Teams

Child Protection Teams are led by professionals with specific forensic medical expertise. Team activities include medical diagnosis and evaluation, medical consultation, nursing assessment, specialized interviews, forensic interviews of children, family psychosocial assessments, psychological evaluation and consultation, and CPT staffing. CPTs assist with identifying immediate safety concerns and risk factors. The CPTs focus on determining whether or not a child has been abused or neglected, identifying the immediate safety factors in a case, and assessing the probability of future abuse or neglect. Interventions are recommended. Quality Assurance reviews throughout the state indicate that progress in working relationships has occurred over the past few years. Opportunities for improvement still remain. There is wide variation in the definitions and assessment of safety and risk. CPIs do not consistently accompany the child to the CPT or take part in the assessment, limiting communication and losing an opportunity for consensus building on safety and risk factors. Inadequate processes are in place to address overall assessments and recommendations to ensure CPT assessment findings are incorporated into dispositional decisions and case planning. There are limited conflict resolution protocols in place.

Finding # 3, Domestic Violence

The Department's primary domestic violence partner is the Florida Coalition Against Domestic Violence (FCADV). FCADV serves as the professional association for Florida's 42 certified domestic violence centers. When family violence threatens child is found as maltreatment, the focus should be on the perpetrator of the abuse and not the non-offending parent, which in most cases involving domestic violence is the mother. Successful interventions in domestic violence cases can not be reached when the perpetrator is not engaged in the assessment and case plan and held accountable for the violence. Current DCF data reveals that 81% of perpetrators were terminated from Batterer Intervention Programs (BIP) for non participation. Additionally, noncompliance was often not met with any consequence.

Finding #4, Substance Abuse

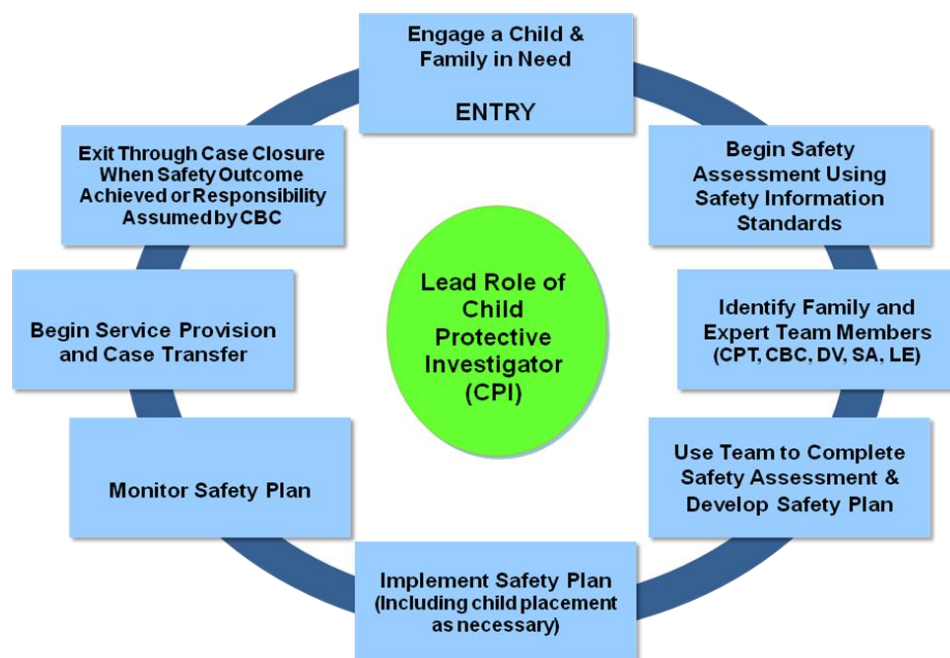
Caregiver substance abuse is an issue present in a substantial number of investigations and is the major reason for children entering foster care. "Family Intervention Specialists" (FIS) were created to improve access and engagement of families in substance abuse treatment when needed. In addition, the Department's substance abuse contracts specify that the treatment needs of priority populations be met, which include parents who put children at risk due to a substance abuse disorder. There is not a uniform or standard protocol for CPI referrals to substance abuse services. Some families get referred directly to the FIS, others directly to treatment providers. Referrals are not driven by safety/risk assessment. Assessment information known by CPI is not always shared with substance abuse assessors, including FIS. FIS assessment results are not uniformly shared with all case management providers. There is not a standard protocol for joint case staffing of families with substance use disorders involving treatment provides, FISs, and child welfare case management agencies. There is not a standardized, statewide method in place to track child welfare referrals to substance abuse providers and outcomes.

Reframing of the Problem

Florida adopted a Family Centered Practice Model which was accepted by the Department of Health and Human Services in 2010. This model serves as the overarching framework that drives all system improvements. The fundamental goal is to ensure that every family involved in the child protection system experiences one team of helping professionals and one common plan. The end result should be team-based decision making with a strong family voice to the extent that it is appropriate. A family team includes the family, youth as age-appropriate, the family's extended family and other informal support persons, as well as professionals with expertise in areas such as substance abuse, mental health, domestic violence, child development and medical care. There are many safety considerations involved as to when it is appropriate to include a perpetrator of domestic violence in a meeting with other family members. Team members should work towards a common understanding of child and family dynamics and safety interventions needed. Plans should reflect the consensus of all team members including the family to the extent possible and appropriate. Team members in every child protection case should have a clear understanding of their respective roles and expectations including how each team member supports a child safety plan and the family's longer term goals for achieving change.

Teamwork with the family, extended family members and other professionals is an essential part of the first responder's role. Teamwork is essential in developing a comprehensive safety assessment and interventions. The CPI plays a key role in establishing the initial team of persons who care about the child and family. Figure 1 displays FCP and the role of the CPI.

Figure 1: Family Centered Investigative Practice



As we move toward enhancing our relationships with external partners, concerted efforts must be made to ensure all parties understand that protecting children and serving families are our mutual goals. Partners should be enlisted to understand and accept the principles within family centered practice, especially, but certainly not limited to communication, engagement and teaming concepts.

Solution Alternatives

System leadership at the state and local levels is required to establish the commitment of all partners to one child and family, one committed and united team. Multiple written agreements with partners are important for describing local implementation details. There should be standardized roles and responsibilities for partners that are common statewide. Current practices that involve “staffing” models specific to each specialized area should be phased out; in place of multiple staffings there needs to be the concept of all team members working to achieve a unified understanding of child and family dynamics and a unified agreement as to how to achieve child safety. CPIs need to be empowered and supported to engage in the teamwork required at the right times and with the right team members. CPIs should determine when face-to-face meetings are needed and which team members need to attend. CPIs need the skills and supports to facilitate meetings of team members in ways that promote the voice of all participants, brainstorming and conflict resolution. CPI Supervisors must provide excellent leadership, modeling and coaching on effective teamwork. There are multiple opportunities every day for Supervisors to model respectful teamwork with both internal and external partners. If Supervisors are not able to engage in excellent teamwork, there are likely other positions that are more suitable.

Attachment 1: Teamwork with Law Enforcement

Current Situation

The Department is the mandated authority to respond to allegations of child abuse, neglect or abandonment in the State of Florida. However, statute has also authorized the Department to contract with county sheriff offices who wish to subsume this responsibility. Currently, seven (7) Sheriffs' Offices have responsibility for conducting child protective investigations in their jurisdictional areas.

Whether the investigation is conducted by the Department Child Protective Investigator (CPI) or by a Sheriff's Office CPI, when responding to allegations that a child has died as a result of abuse, neglect or abandonment, or has been a victim of possible physical and/or sexual abuse, the CPI must enlist the assistance of law enforcement to determine if criminal charges may be warranted. Florida Statute also requires law enforcement involvement when there are allegations that a child has been abused or neglected while in an institution, i.e, child care home or facility, foster home, residential facility, etc. In addition, CPIs often request law enforcement assistance when they must remove a child from the home, or if they fear for their own safety, or if there are other factors that so warrant a joint response.

Given all of these possibilities, law enforcement is involved in child protective investigations in some capacity and to some extent very frequently, so there is an urgent need that CPIs and local law enforcement entities build and nurture strong, effective working relationships and partnerships that keep children safe and protected.

Phase 2 Work and Findings

At the CPI Summit in June 2011, participants were asked, "In a successful investigation involving law enforcement, what was the best work a law enforcement partner contributed?"

They responded with the following feedback:

- Providing debriefings of the case and what their [law enforcement's] role will be.
- Developing rapport with child and family.
- Openly communicating with involved parties.
- Understanding and respecting the CPI's objectives and roles and responsibilities.
- Providing access to criminal histories including non-criminal "calls-to-the-home."
- Knowing when to involve the Department.
- Providing accurate details when reporting allegations to the Florida Abuse Hotline.
- Demonstrating patience while in the subjects home

One strategy to help CPIs and law enforcement work well together is through local Memorandums of Understandings (MOUs). Florida Statute requires the Department to enter into MOUs with the jurisdictionally responsible Sheriffs' Offices and local police departments to respond to child protection concerns.

Reviewing current MOUs revealed that there are currently 241 of them and they are considerably inconsistent in how they are written and executed. They vary in purpose, authority, definition, policies and procedures, and range in length from as few as seven (7) pages to as many as 28 pages. In addition to the differences in the level of detail, there is also noted discrepancy as to the level of implementation and adherence. Some of the MOUs include good practices while others are written at a very high level.

Another finding is that there is a 35% turnover rate of CPIs. This makes it extremely challenging to develop and sustain working relationships with the many different law enforcement entities that have such varied operations and processes; yet, CPIs are expected to be informed about all of the differences as they respond to reports in the various counties.

Reframing of the Problem and Benefits

Both workforces (CPIs and local law enforcement entities) are expected to do a lot of work within limited time frames in order to protect children and keep them safe. Both workforces have the same goal in this regard, but each faces many challenges that must be overcome. In order to do that, continuing attention must be given to ensure effective communication, collaboration, and teaming processes are solidly in place and supported on an ongoing basis.

How responders handle interviews and how evidence is gathered must be carefully coordinated.

Additionally, both workforces may have conflicting priorities; law enforcement may need to make a much quicker decision as to whether or not a crime has been committed as compared to the CPIs need to more methodically, complete a thorough assessment of the entire situation. This can cause some strain from law enforcement's perspective in that they can get tied up for an extended amount of time while the CPI completes documentation, safety plans, and other forms of documentation that are required.

There are also some jurisdictional issues related to the location of the potential crime versus the child. There are conflicts between agencies and responders when the alleged abuse, neglect or abandonment occurred in one county's jurisdiction, but the child is in another jurisdiction (in hospital or otherwise). For example, if a child was physically abused in one county and placed in the hospital in another county, the protective and criminal investigations are hampered if the agencies are unable to share resources.

The wide variety and content of MOUs and high turnover rate previously mentioned remain a part of the problem.

Solution Alternatives

Stabilize the workforce and develop very specific MOUs that spell out individuals' roles and responsibilities based on the request for law enforcement involvement and include various stakeholders in the process. MOUs should clearly define mutual expectations in responding to each of the types of

requests cited above; the who, what, when, where and how the two entities will come together to protect children and keep them safe.

For instance, if the request involves a potential criminal investigation, the MOU should very specifically address and define who responds and when, what activities will be involved, and how the work will be completed. If the request was for assistance because the CPI had to remove a child, the MOU should specify the responsibilities of both workforces that would be different from the criminal investigative activities.

Some of the better MOUs that were reviewed included good practices and should be considered for replication. For instance,

- MOU allows local law enforcement to have access to FSFN and if possible have CPIs co-located with them. This creates an environment by which both workforces can share information quickly and easily while naturally creating camaraderie around a mutual cause.
- MOU clearly identified and strengthened reporting and responding expectations when managing a missing child situation so that each party understands their individual roles and responsibilities to locate the child and keep the child safe.
- MOU required regularly scheduled joint meetings and training sessions in order to nurture and build effective teams and partnerships. This provides an environment by which conflicts can be resolved, ineffective processes can be improved and attention re-focused on the mutual goal to protect children.

Existing practices reported by regions across the state include:

- “We are planning our next interagency meeting in November with a focus on improving our working relationship with the local Sheriff’s Office.”
- “We have many police departments and we do not have a strong working relationship with all of them, but have developed a partnership with some of the smaller departments and will continue to work on strengthening others.”
- “We recently made some progress with our local Sheriff’s Office and they invited us to participate in their planning meetings prior to a drug raid, so we were prepared to assist where needed. Opportunities for strengthening the working relationship remain.”
- “We have a wonderful relationship with all of the local law enforcement agencies. We recently renewed our MOUs and they each remain eager to assist us with anything we need.”
- “We have some difficulties obtaining local law enforcement checks, but we are working on a win-win solution where we can provide staff to assist.”
- “We meet monthly with our States Attorney and local law enforcement agencies to discuss critical cases. Narcotics units work well with us as we have a Drug Endangered Children pilot in this area where we developed a protocol for responding to and handling meth labs and

grow houses. We share case information as appropriate with Narcotics units and vice versa.”

Recommendations

Overall, CPI and local law enforcement agencies are working fairly well together, but because each plays such an important and critical role in protecting children, ongoing efforts to enhance and nurture effective working relationships must be a priority within the local systems of care.

The following recommendations are submitted for consideration:

1. Consider standardizing the MOU template with the minimum requirements that everyone must meet, but with ample opportunity for local agencies to enhance and provide specific details. Include representation from various stakeholder groups to improve teaming.
2. Local agencies should have regularly scheduled team-building activities and meetings or discussions to review cases and resolve any potential conflicts quickly.
3. Local entities should develop a plan in order to respond to cross-jurisdictional issues. Since law enforcement and CPIs have the same goal to protect children and keep them safe, the same protective processes should be in place whether the child and potential crime are in the same county or not. A chain of command should be in place that ensures someone is clearly identified to take charge of the criminal investigation as well as the protective investigation. Any possibility that someone thinks someone else is doing the work necessary could result in unwanted consequences.

Attachment 2: Teamwork with Child Protection Teams

Current Situation

The Child Protection Team (CPT) Program operates on the premise that child abuse, abandonment, and neglect is a multifaceted problem requiring a multidisciplinary response to reports requiring child protective investigations. The purpose of the program is to supplement the child protective investigation activities by providing multidisciplinary assessment services to children and families involved in child abuse and neglect investigations. Child Protection Teams may also provide assessments to Community Based Care providers to assist in case planning activities when resources are available.

The teams' comprehensive multidisciplinary assessment activities are critical in identifying and evaluating child abuse, abandonment, and neglect, in recommending effective interventions and treatments, and in securing successful long-term outcomes for children and families.

Upon receipt of a report alleging child abuse, abandonment or neglect, child protection staffs are responsible for identifying and referring all appropriate children to the Child Protection Team for assessment services. Subsection 39.303 (2), Florida Statutes, specifies the types of cases that must be referred by CPIs to the Child Protection Teams for assessment and other appropriate available support services. Mandatory referral cases include those involving:

- Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age
- Bruises anywhere on a child five years of age or younger
- Sexual abuse of a child. *Sexual Abuse Threatened Harm is not mandatory. Victims of child on child sexual abuse, or alleged juvenile sexual offenders (children 12 years of age or younger) may be accepted for team services but are not mandatory referrals*
- Any sexually transmitted disease in a prepubescent child
- Reported malnutrition of a child and failure of a child to thrive
- Reported medical neglect of a child
- Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home
- Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected

The medically led, multidisciplinary team assessment process is instrumental in assessing maltreatments, identifying immediate safety concerns and risk factors in reports of suspected child abuse, abandonment, and neglect. The assessment process is focused on determining whether or not a child has been abused or neglected, identifying the immediate safety factors in a case, and assessing the probability of future abuse or neglect. By identifying the risk factors, appropriate and effective interventions are recommended to reduce the level of risk and improve safety for children.

Team assessment activities include, but are not limited to those listed in s. 39.303, F.S. These activities include medical diagnosis and evaluation, medical consultation, nursing assessment, specialized interviews, forensic interviews of children, family psychosocial assessments, psychological evaluation and consultation, and CPT staffing.

Currently the CPTs are utilized in varying capacities across the state. Some cases meeting mandatory criteria are not referred to the teams. Additionally, some teams indicate that even when referred, CPIs are closing their cases prior to receiving the results of the CPT assessments. In some areas, CPIs simply make a referral and do not participate in the assessment process. In other areas, the CPI attends the assessments and fully participates in the process. The shared goal is consensus on maltreatment findings, safety and risk concerns, and conclusions and recommendations.

Phase 2 Work and Findings

At the CPI Summit in June 2011, participants were asked, “In a successful investigation involving the need for the Child Protection Team, what was the best work the CPT contributed?”

They responded with the following feedback:

- Making appointments that are sensitive to the child and family’s schedule.
- Understanding that an undetermined status impacts the decisions that can be made.
- Insuring consistency between the verbal and written reports.
- Making a timely request for records.
- Having a quick response – especially after hours.
- Providing timely reports to support shelter hearings.
- Maintaining open time slots for emergency situations.
- Being available to testify in court.
- Having collaborative relationships.
- Facilitating Multi-disciplinary staffings.
- Being knowledgeable about the Florida Safe Families Network (FSFN).

Child Protection Teams were surveyed to determine where they believe breakdowns in service delivery occur and what changes in practice might improve service delivery and outcomes. Concerns were voiced in these primary areas:

- Mandatory cases were frequently not referred (or referred too late) with no agreed upon decision that CPT assessments were not needed.
- Child Protective Investigators in many areas of the state do not accompany the child to the CPT or take part in the assessment, limiting communication and losing an opportunity for consensus building on safety and risk factors.

- Inadequate processes are in place to address overall assessments and recommendations to ensure CPT assessment findings are incorporated into dispositional decisions and case planning.
- There are limited conflict resolution protocols in place and high case loads and turnover.

The Child Protection Teams were also surveyed to assess the level of substance abuse expertise available in their assessments. Substance abuse expertise was sorely lacking. Furthermore, frequently no one with this expertise is included in cases that are serious enough to require staffing and in which substance abuse is identified as a family dynamic.

Reframing of the Problem and Benefits

Florida has a unique system in place to assist investigators that is currently somewhat underutilized. In some cases CPI and Child Protection Teams are not working together as closely as they might in order to assess maltreatment, safety and risk concerns, and dispositional decisions. Breakdowns in communication cause safety concerns identified by professionals to go unnoticed or inadequately addressed. Substance abuse expertise in particular is needed to help in the CPT assessment process.

Child Protection Teams and Child Protective Investigators need a consistent framework for safety and decision making. Quality Assurance reviews throughout the state indicate wide variation in the definitions and assessment of safety and risk. When risk “factors” are identified but no consistent approach to rational decision making is utilized, safety plans are insufficient and case plans ineffective. Further exploration is needed to identify where in the state the system is working well and subsequently replicating those effective processes in places where it is not.

Solution Alternatives

In an effective investigation partnering with CPT on a mandatory referral, the CPI would not only help facilitate the scheduling of the appointment, but would also ensure all members of the child’s team (people who care about the child’s safety) are engaged in the process and are helping make appropriate plans for the child on-the-spot. Promising practices reported by CPT staff across the state include:

- “The most promising practices include a true “team” approach. When CPIs and CPT staff discuss the case during the intake process, enhanced background knowledge is achieved and consensus is reached regarding the need for particular CPT assessments. The CPI is present for the CPT assessments and takes part in the provision of services. Following the medical exam, the doctor, case coordinator and CPI discuss findings and plans for the safety of the child. CPT provides a preliminary medical report with impressions, risks, and recommendations. It is signed by the medical provider, case coordinator and CPI and the CPI takes a copy as they leave the CPT office. This is used in their staffing with CLS when necessary.”

“Our satellite offices are a blessing to DCF folks in the field. I would encourage all of CPT to approach viable agencies/programs/counties to acquire in kind space. Even if limited to providing interviews, psychosocials, staffings, holding task force meetings, etc. PIs are more inclined to attend if provided in the community with little travel required. We have found a strong buy in for locating (for example, one Sheriff asked me to write a request for CPT services to be included in a multimillion dollar grant. I requested new recording equipment in our in kind office in that county. They got the grant, about 3 million, and we get money for our equipment. In another county, I sent a request to the SAO and they piggy backed off the Sheriff’s office and added an extra recording unit, then placed it in our suite at the local hospital.) Partners’ pulling together is imperative in these times of limited resources.”

- “The CPT team discusses every FSN report during a daily morning meeting, which includes a variety of community partners, the Team Coordinator, the Medical Director, and a DCF employee. The DCF employee is able to immediately provide the CPI’s with information regarding their new cases – if they are mandatory for services and/or if the MD is requesting to see the child. This is very helpful to the CPI’s and reduces the time it takes for them to refer a case to CPT.”

“We also come together with CPI’s and other community partners on a weekly basis during CAC staffings to discuss all of the cases from the previous week. This gives everyone the opportunity to address where they are in their investigation and is a great opportunity for CPT to be able to share our protective factors, risk factors, recommendation, and findings with the CPI’s. CPT has a good working relationship with the CPI’s. The CPI’s call and discuss cases with case coordinators all the time – whether it is to discuss an upcoming service, a completed service, or an exception to a mandatory referral. I think that open communication is the most critical component of best case practice between CPT and CPI’s.”

- “Our case coordinator responsible for intake goes out to the three DCF service centers once a week to follow up on any referrals that were pending additional information, obtain referrals on mandated cases that had not been referred. The case coordinator will also provide training to DCF staff while at the service centers.”
- “We hold a conference call in the morning. It is a dedicated line for the CPIs to make referrals on new cases. They send us the case numbers in advance and then we take all of the additional intake information during the call.”
- “Regular training with new CPI's as they are going through their initial training, is valuable to orient them to CPT, the services we provide, help interviewing techniques with children to obtain good/reliable information as well as understanding the family dynamics and how it may affect children's statements. If teams statewide could coordinate with the person responsible for the regional training, that would be great not only in providing additional training, but building and maintaining a professional relationship. Also, during this training, the new CPI's should learn how to

refer to CPT, what should be referred as well as the information needed to obtain a referral. A guideline was developed (attached) for use by CPT when accepting new referrals. If all teams would use this list and familiarize the CPI's with the needed information, it would make the referral process smoother and more productive.”

Recommendations

- 1) Efforts must be made to ensure CPT services continue to be accessible when and as needed in local communities requiring limited travel for children and their families. The Departments of Health and Children and Families should encourage co-location of CPIs and CPTs by utilizing satellite office space in either existing Children’s Advocacy Centers or in DCF area offices.
- 2) Child Protection Teams should receive specialized training to expand knowledge and assessment of substance abuse and domestic violence dynamics.
- 3) Joint training at the regional level should occur frequently to ensure consistent understanding and approach to assessment and findings. Training should include CPIs spending time with Child Protective Teams to gain better understanding of the role and function of CPT.
- 4) There should be one staffing with multiple partners to share assessment findings and develop agreement as to safety actions. The Department should standardize the expectation for one staffing rather than the current multiple staffing requirements (CLS, CBC, etc.).
- 5) In addition to providing input into the investigation’s maltreatment findings, Child Protection Teams should be included as critical partners in addressing immediate safety and potential future risk concerns for the child and family.
- 6) Child Protection Teams and Child Protective Investigators should adopt a standardized framework for safety and decision making. Quality Assurance reviews throughout the state indicate wide variation in the definitions and assessment of safety and risk. When risk “factors” are identified but no consistent approach to rational decision making is utilized, safety plans are insufficient and case plans ineffective.

Attachment 3: Teamwork in Child Welfare Cases involving Domestic Violence

Current Situation

For the past 12 years one of the most reported maltreatments in Florida has been *family violence threatens child*, meaning there's an allegation that domestic violence occurred in the home. Historically in this type of investigation the CPI has routinely focused on the mother as the primary caretaker of the children. The most significant problem with this response is that it places the adult victim in the position of being held responsible for the perpetrator's behavior and does not take into consideration the perpetrator's tactics of coercive control or, the victim's previous or current efforts to support the safety and well being of her children. When child abuse investigators focus the investigation and solutions on what the non-offending parent should do to protect her children, CPI's inadvertently and most often unintentionally collude with the perpetrator (batterer) and his abusive actions. Traditional solutions offered to non-offending parents include leaving the residence and entering a domestic violence emergency shelter or other location; filing for a restraining order; calling the police; and, reporting any further incidence of domestic violence. These solutions may be useful for some families; however, for others, these examples often increase the risk of violence by the perpetrator. This is a problem across the country that many child welfare systems are addressing.

When family violence threatens child is found as maltreatment, the focus should be on the perpetrator of the abuse and not the non-offending parent, which in most cases involving domestic violence is the mother. Successful interventions in domestic violence cases can not be reached when the perpetrator is not engaged in the assessment and case plan and held accountable for the violence. The Department of Children and Families website reflects that from 07/01/10 – 6/20/11, 81% of perpetrators exited from Batterer Intervention Programs (BIP) for non participation. Therefore, while batterers may be ordered in dependency cases to attend BIP, they are often not attending. Additionally, noncompliance was often not met with any consequence. Failure to hold the perpetrator accountable for participation and completion of a BIP, safety plan or other services that focus on behavioral changes of the perpetrator has long term negative consequences on the family's safety.

The Department's primary domestic violence partner is FCADV. FCADV is the statewide expert on domestic violence and its mission is to work towards ending violence through public awareness, policy development, and support for Florida's domestic violence centers. . FCADV serves as the professional association for Florida's 42 certified domestic violence centers. FCADV's Training and Technical Assistance Department offers on-site training and technical assistance to domestic violence center staff and other professionals working with survivors of domestic violence and their children. The Coalition administers state and federal funding earmarked for centers and as such, they possess a comprehensive quality assurance department responsible for ensuring both administrative and programmatic standards are achieved. FCADV partners with the certified centers to ensure optimum provision of services to survivors of domestic violence and their children. The Coalition is also actively involved in developing

and implementing domestic violence-related public policy that strengthens penalties for perpetrators and enhances services for survivors of domestic violence and their children.

DCF has a longstanding collaborative relationship with FCADV that includes strategizing and resolving issues surrounding the impact on families experiencing domestic violence. FCADV and the Department successfully work together to bring awareness and support to DCF and the Department's primary customers on the dynamics of domestic violence, and the impact that violence has on adult victims, their children and the entire community. This is accomplished through ongoing training and consultation.

Phase 2 Work and Findings

Domestic violence experts all agree that when CPI's and case managers partner with the non-offending parent (in most cases the mother) in their efforts to protect the children, while holding the perpetrator accountable will result in positive outcomes for the family. Several years ago many DCF agency administrators recognized and encouraged a systemic altering of local protocols involving DCF child welfare professionals working with families experiencing domestic violence. Based on available funding, consultative services were contracted with David Mandel & Associates, and the *Safe and Together Model* was introduced to several DCF agencies. Since that time there have been strong collaborative efforts to introduce this model practice in numerous DCF and Sheriff Department agencies conducting child abuse investigations.

David Mandel and Associates' *Safe and Together Model* offers a protocol for child protective investigators in domestic violence cases that focuses on four parts:

- A. Questions for the primary caretaker,
- B. Questions for the children,
- C. Questions for the partner or ex-partner and,
- D. Questions to help with assessment and case planning.

The first three parts of this protocol provide a structure for interviewing the family and the last part assists the child protective investigator in the evaluation of the information they have received from the family. The evaluation will lead to development and implementation of safety strategies for the non-offending parent and children as well as compliance based behavioral oriented tasks for the perpetrator. This change in practice supports the key shift in historic thinking needed regarding case management issues where domestic violence is identified.

Currently, FCADV has facilitated partnerships with six Sheriffs' Departments that conduct child abuse investigations, along with each community's local certified domestic violence center. This project is known as the Child Protective Investigator Project (CPI Project) and has begun its third year. The Project co-locates domestic violence advocates in each of the six Sheriff's Offices who conduct child protective investigations. The sheriff's have been trained by FCADV and have adopted the *Safe and Together*

model. Six Florida's sheriffs' departments participate in the FCADV child protective investigation project that was originally funded from the American Recovery and Reinvestment Act (ARRA) federal grant funds, and is now partially sustained from federal grant funds administered by the Florida Attorney General's Office (AG). The grant money pays to have a domestic violence advocate co-located in each of the (6) participating sheriff offices. (Pinellas, Citrus, Pasco, Hillsborough, Manatee and Broward). The advocates provide domestic violence case consultation services with sheriff CPI's).

The goals of the project are:

- To provide immediate services to adult victims and their children in order to reduce child removals from non-offending parents;
- To provide consultative services and training to child welfare professionals to enhance their skills and knowledge in responding to families experiencing domestic violence.; and,
- To increase perpetrator accountability.

Other projects throughout Florida that have implemented effective strategies for domestic violence cases include:

- Palm Beach County DCF developed the *Palm Beach County Child Protective Investigations Domestic Violence Protocol* and it can be found at: <http://www.pbcgov.com/criminaljustice/childabuse/> (additional information is also available);
- Duval County has developed specialized CPI units with domestic violence experts trained by David Mandel and Associates, and they also have a community-based domestic violence advocate co-located in the CPI Duval County service center;
- Circuit 1 CPI's have developed a protocol for domestic violence child abuse investigations;
- Sarasota DCF developed a partnership with their local community-based domestic violence center based on the CPI project model CPI project with the Manatee County Sheriff child protection unit; and

Based on the unique set of circumstances involving safety issues for both professionals and families, DCF will continue partnerships with FCADV to consult on identifying and finding solutions to working with families experiencing domestic violence.

Reframing of the Problem and Benefits

The most promising best practices utilized today by Florida's communities includes the willingness of child welfare professionals to explore, negotiate and contract with domestic violence experts to assist CPI's, and administrators in reframing the investigative process, by recognizing and holding the perpetrator accountable, and not the non-offending/caretaker parent. Proposed best practice in child abuse investigations and case management in domestic violence investigations should include:

- Seeking shelter and dependency petitions regarding only the perpetrator, and offering voluntary family centered services to survivors and their children;
- Referring to a certified domestic violence advocate within 24-48 hours of the initial abuse investigation;
- Developing compliance-based and behaviorally-oriented safety plans and case plans with the perpetrator that seeks to hold the perpetrator responsible for the safety of the non-offending parent and children;
- Engaging the perpetrator into batterer intervention programs (BIP);
- Investigating other types of court orders including statewide and national, such as criminal no contact orders, injunctions for protection or conditions of probation that can be utilized to protect the family and hold the perpetrator accountable; and,
- Utilizing the Florida State Statute 39.504 that allows for an outside entity to seek a protective injunction against the perpetrator to remove the offender from the household even if the perpetrator is not the parent to any of the children in the case.

The use of the *Safe and Together* model as a preferred response in domestic violence cases offers all the tools necessary for child protective investigators to properly interview, identify and implement effective strategies to enhance safety for children in homes where domestic violence exists. In addition, the model provides Children's Legal Services with the tools for documentation of domestic violence cases for appropriate presentation of cases to the court that focus on the coercive control pattern of the perpetrator and the non-offending parents' efforts to support the safety and well-being of their children.

It is important that child welfare professionals, such as protective investigators receive specific training on the dynamics of domestic violence. Training should include information about victimization, safety assessment, community resource networking, and how to best problem-solve safety strategies with families where violence exists. It is critical that when intervening, child welfare professionals properly identify the perpetrator's coercive control tactics and their adverse impact on the family. Protective Investigators must also be able to recognize domestic violence as a social problem needing a coordinated community response.

Protective investigators should be well trained in tactics perpetrators utilize to maintain power and control. Holding the perpetrator of domestic violence accountable and focusing case plan compliance on the perpetrator is essential. Protective Investigators need training to learn how to develop and follow through on strategies to hold perpetrators responsible for further violence. Local agreements with law enforcement, state attorneys (SAO) courts, and local probation departments are essential in order to have a coordinated, community response that holds perpetrators accountable. In addition, the use of dependency court orders to hold perpetrators accountable is an essential strategy.

Non-offending parents and their children may need resources such as childcare, transportation, employment and housing which are integral services in proving safety and sustainability of the family.

Protective Investigators need to convey who in the community can provide such resources. Protective Investigators also need to understand the unique confidentiality laws associated with domestic violence cases, and understand that some information cannot be shared with anyone unless specifically approved by the non-offending parent. The confidentiality laws are designed to protect the non-offending parent and the children and do not impede an investigation. The ultimate goal is to keep the family safe from the perpetrator.

In addition, children's legal services need training on how to develop cases to present to the court that focus on perpetrator accountability and not simply the adult victim's/non-offending parent's capacity to protect the children. Training opportunities should be provided for Children's Legal Services on information such as how to request orders of protection on behalf of the child and how to present information to the court when the perpetrator is non-compliant with safety plans, case plans or other requested tasks.

Solutions must be focused on training for Child Protective Investigators that increases their capacity to interview, identify, and implement solutions that increase safety and hold perpetrators accountable for their violence.

Solution Alternatives

The following recommendations address best practice protocol and offer solutions for sustaining a competent child welfare protective investigation staff working with families experiencing domestic violence:

- 1) Every CPI unit in the state should follow a standard set of guidelines when working with families experiencing domestic violence. These guidelines should be developed by the Family and Community Services Office with input from FCADV. The guidelines should include the expectation for court-ordered participation in interventions for perpetrators.
- 2) Every CPI unit in the state needs to have a working memorandum of understanding (MOU) with community partners from the local certified domestic violence centers and law enforcement agencies which describes the local protocol for implementing the standardized guidelines for domestic violence child abuse investigations. Each MOU should be descriptive of who performs what function, and how each member of the team responds to such cases where there are state and federal laws directing case confidentiality, unique to other types of investigations.
- 3) Every existing CPI and all in-coming new CPI's should receive specific training curricula for domestic violence case assessment and safety planning. This should include domestic violence case law for s.39.504.
- 4) Holding perpetrators accountable must be accomplished in a systemic uniform directive where domestic violence perpetrators will be referred to batterer intervention programs (BIP) and every one will be followed for compliance. MOU's will be developed between law enforcement, state attorneys (SAO) courts, and local probation departments to ensure a seamless tracking of the perpetrators engagement and completion of the BIP.

- 5) The *Safe and Together Model* should be required curricula in all CPI training. As part of the new statewide training certification every CPI should be required to receive yearly CEU's in the Safe and Together model.
- 6) DCF CPI units should be encouraged to design their CPI units after the current (six) sheriff departments that are engaged in the CPI projects where domestic violence advocates are co-located in sheriff offices conducting child abuse investigations. Local strategies should be developed for ensuring that DV Advocates are available to provide consultative services to the CPI's in domestic violence cases.
- 7) Develop one or two (1 rural and 1 urban) pilot projects, and track for two years. Every family violence case with verified findings would be required to have a 39.504 injunction. Court order would only apply to the male perpetrator. (Florida approved batterer intervention programs (BIP) do not recommend women participants). The non-offending parent would not be held responsible to be part of the case plan. Successful completion of the BIP would become paramount to court order. During the project/s data would be captured comparing re-abuse rates for the maltreatment *family violence threatens child*, with non-pilot areas. Outcome expected: pilot projects having BIP participants who successfully completed court-ordered BIP would have lower re-abuse rates than non-participating project areas of the state.

Attachment 4: Teamwork in Child Welfare Cases involving Substance Abuse

Background and Current Situation

One of the major reasons children enter foster care nationwide is abuse or neglect associated with parental alcohol or drug abuse.ⁱ In Florida in 2009, parental alcohol or drug abuse was the reason for removal for 44 percent of children whose parents had parental rights terminated.ⁱⁱ The abuse of alcohol or drugs is a significant risk factor associated with child safety. In a May 2011 Chapin Hall review of the National Survey on Child and Adolescent Well-Being Survey, the authors found that caseworkers reported active alcohol or drug use by parents or caregivers for almost 41 percent of older children and 61 percent of infants in foster care.ⁱⁱⁱ The behaviors of caregivers when under the influence of alcohol or drugs often directly interfere with the adequate attention, care and supervision that is especially vital to developing infants and young children. Caregiver behaviors may include uncontrolled anger or other emotions. The persistent stress for children of not knowing what caregiver behaviors to expect and depend on can alter their ability to learn, to manage their own emotions and to establish relationships with other adults and peers. The consequences for children can be life-long. Frequently there is the co-occurrence of substance abuse and dependence with mental illness.^{iv} The overwhelming majority of women in substance abuse treatment have experienced trauma in their lives, either as victims of abuse and neglect as children, or as victims of domestic violence as adults. Effective treatment will include the identification and management of co-occurring disorders and the impact of trauma as a barrier to recovery

In Chapter 39, the Florida Legislature established the following goals related to substance abuse treatment services in the dependency process: (1) To ensure the safety of children; (2) To prevent and remediate the consequences of substance abuse on families involved in protective supervision or foster care and reduce substance abuse, including alcohol abuse, for families who are at risk of being involved in protective supervision or foster care. (3) To expedite permanency for children and reunify healthy, intact families, when appropriate. (4) To support families in recovery.

The General Appropriations Act established a child welfare performance outcome measure, *“Increase the number and percent of individuals (adults) in protective supervision who have case plans requiring substance abuse treatment who are receiving treatment.”* A manual review of over 1000 from CBC agencies in 2004 found that 44 percent had case plans requiring one or more parents to participate in substance abuse treatment. Twelve CBC providers either met or exceeded the state target of 55 percent. The Department lacks the automated capacity report on this performance measure. The Department has completed design work to implement an information sharing initiative between the statewide child welfare information system and the substance abuse information system to capture data on this outcome measure. This project is currently “on hold” given other system development priorities.

The federal Child and Family Services Review (CFSR) of the Florida child protection system in 2009 found that substance abuse by parents was the reason for case opening 29% of the time in out of home cases; 21% of the time in in-home cases. Studies have documented that substance abuse often goes undetected in the early phases of child welfare case. Substance abuse was reported in the federal review to highly impact repeat maltreatment. The review found that assessments completed did not detect substance abuse issues at early stages of child welfare system involvement, leading to inappropriate case plan interventions. The CFSR also found that substance abuse and/or mental health treatment services for parents were not adequately available.

Phase 2 Work and Findings

Florida has a unique resource dedicated to improving treatment outcomes for families involved in the child welfare system. “Family Intervention Specialists” (FIS) were created and funded by the legislature in Fiscal Years 2001-2002 and 2003-2004 to improve access and engagement of families in substance abuse treatment when needed. The Department’s substance abuse contracts specify that the treatment needs of priority populations be met. Parents who put children at risk due to a substance abuse disorder are one of those priority populations.

There are 89.5 FIS positions contracted to 18 substance abuse treatment providers through-out the state providing services in all but five counties. FIS Guidelines are included as an attachment to these contracts. The FIS work with and most are co-located with CPIs or case management (CM) staff. FIS responsibilities include:

- Taking referrals from investigators or case managers.
- Provide initial screenings and assessments.
- Provide linkage for evaluation and treatment as indicated.
- Provide treatment-related case management.
- Motivate and support the family and assist in removing barriers to successful substance abuse treatment outcomes.
- Track and report on the progress of individual referred.
- Provide information and recommendations for development and case management of the joint family service plan.
- Work with the child welfare CM to ensure compatibility between the substance abuse treatment goals and child welfare plans and interventions.
- Can enter case note information directly into Florida Safe Families Network (FSFN) and access other case information entered in the child’s FSFN record.

Circuit program offices currently have wide latitude to develop local policies for the use of the FIS resource, and several have incorporated the use of Family Intervention Specialists in their Family Preservation Protocols. There are some existing agreements in Florida between the circuit and substance abuse provider as to the specific use of the FIS positions that are recognized as promising approaches. The common elements of these agreements are:

- Priority for FIS services is given to children at risk for immediate removal or who have been removed.
- FIS is co-located with CPI or CM unit.
- FIS services are available to conduct joint home visit with CPI to engage and assess family.
- FIS caseloads are limited to ensure reasonable level of oversight, family engagement, and response times.
- FIS is responsible for toxicology chemical dependency screening if appropriate.
- FIS completed bio-psycho-social assessment within agreed upon timeframes. The assessment is scanned into FSFN. Both CPI and Case Manager are alerted to assessment completion.
- FIS provides weekly contact to family referred for treatment to ensure that follow up treatment is accessed.

During the past year, the department has utilized technical assistance from the National Center on Substance Abuse and Child Welfare (NCSACW) to identify opportunities to improve practice in cases involving substance abuse. The NCSACW uses a technical assistance framework that defines ten elements of system linkages that are essential.^v This framework is used to organize collaborative activities between child welfare and substance abuse providers in practice and policy areas. *“Screening and Assessment of Family Engagement, Retention and Recovery, SAFER”* is a groundbreaking practice document developed by a team of national experts and practitioners from both fields.^{vi} *SAFER* provides the current, best practice approach to effective communication across systems while engaging families in substance abuse treatment services.

Technical assistance by NCSACW has been provided to the Department’s state child welfare office and also in Circuits 4, 10, 11 and 14. An in-depth review of substance abuse and mental health screening and assessment tools/protocols was conducted.^{vii} Detailed recommendations to improve current processes were developed and are incorporated in the Solution Alternatives section of this paper.

In addition to manual drop off analysis to determine the number of parents with substance use disorders in child welfare who received and completed treatment services in three circuits, other technical assistance activities were undertaken to determine where gaps exist. Given department quality assurance findings statewide, it is believed that these are common, consistently occurring challenges:

- The lack of a uniform or standard protocol for CPI referrals to substance abuse services. Some families get referred directly to the FIS, others directly to treatment providers. Referrals are not driven by safety/risk assessment. Assessment information known by CPI is not always shared with substance abuse assessors, including FIS. This can lack of information can seriously compromise the substance abuse evaluation. Circuits 4, 11 and 14 have implemented standardized referral procedures and referral information from CPIs to the FISs and treatment agencies.
- Lack of referral to case management agencies for follow up to ensure that treatment services are received and successfully completed. FIS assessment results are not uniformly shared with all case management providers.
- Lack of a uniform way to screen, identify and intervene in cases involving substance exposed infants, and respond to notifications from health care professionals for newborns who are

substance exposed. Currently, there is no circuit or statewide tracking system to identify how many substance exposed newborn families are referred to the child welfare system from health care professionals.

- The lack of a standard protocol for joint case staffing of families with substance use disorders involving treatment providers, FISs, and child welfare case management agencies as to which program best meets family needs and presenting issues.
- Parallel systems operating among providers (substance abuse, mental health, and case management agencies). Referral information and progress reporting are not standardized. Circuit 4 has standardized referral information and progress reporting across all case management agencies and substance abuse treatment providers.
- Lack of follow-through and joint case staffing when case management is being provided to ensure that treatment recommendations are followed and to monitor progress in treatment.
- CPIs (and case managers) lack of understanding about what constitutes effective SA treatment and ways to support both treatment and recovery.
- On-going challenges with providing in-home substance abuse services and the need to assess substance abuse services options for children and families.
- Lack of consistent availability of evidence-based parenting programs for families affected by substance abuse. (e.g. Nurturing Families, Strengthening Families),
- Manual data analysis conducted of families referred for evaluations and treatment shows several specific areas needing attention:
 - High volume of FIS screening and assessments results in limited capacity to engage families to connect to treatment services.
 - Many parents are getting screened and assessed, but far fewer parents are entering and completing treatment.
 - While FIS assessments are usually conducted on a timely basis (within 72 hours), the time to access treatment services is often much longer. Inadequate attention to the service needs of children in families with substance abuse disorders.

All of the above challenges to ensuring adequate evaluation and provision of substance abuse treatment services result in delays to resolving the issues that threaten child safety, well-being and ultimately permanency resolution.

Reframing of the Problem and Benefits

To accomplish good outcomes for children whose families have substance abuse disorders, CPIs and case managers must establish strong teamwork with the FIS as well as alcohol and drug abuse providers. CPIs must have basic skills required for effective screening of possible caregiver substance abuse. Skills required include review of past case history, knowledge-based observations of the home environment for indicators of alcohol and drug involvement as well as motivational interviewing skills. Interviewing skills must incorporate basic screening questions and should be direct and non-threatening.^{viii} Motivational interviewing and engagement skills must be incorporated in CPI, case management, and substance abuse staff competencies. CPIs and case managers must well-understand the stages of recovery and related family dynamics. This level of understanding can be achieved through years of experience as well as teamwork with a substance abuse professional. The NCSACW also offers a free on-line tutorial for child welfare workers on working with families with substance use disorders. CPIs must also know how to interview children about parental substance abuse. CPI processes and assessment

tools must clearly require consistent information gathering about substance abuse. CPIs must be able to assess threats in the family to child safety and identify child vulnerabilities that in the context of caregiver substance abuse endanger children.

Assessment information gathered by the CPI must be conveyed to the substance abuse Family Intervention Specialists and treatment professionals so that the assessment does not depend only on family self-report. The CPI needs ways to ensure that when needed, substance abuse assessments are completed; when assessments identify a need for treatment there must be appropriate child welfare interventions and supports provided to ensure that treatment services are able to be accessed. The FIS should ensure that CPIs are assisted in working with families to promote motivation for treatment, to access needed substance abuse assessments, identify appropriate treatment choices, engage families and identify support needs related to access and participation in treatment. Treatment agencies need to provide timely access to effective treatment services, and be willing to individualize services to meet the needs of families in child welfare.

Solution Alternatives

These recommendations are based on the NCSACW review of Florida's processes, tools and local practices, as well as the Department's own quality assurance findings:

- 1) **Screening Process.** Basic screening for substance abuse should be an expectation and skill set that CPIs have and use in every investigation. The department should adopt a standardized substance abuse screening tool such as the UNCOPE for Adults and the CRAFFT for youth. When an emergency placement is needed and the CPI conducts the initial Unified Home Study, questions of the potential caregiver as to substance abuse should be asked. Both the Child Safety Assessment and the Unified Home Study instrument should be modified to include appropriate screening information. Department guidelines should include clear expectations for standards related to toxicology chemical dependency screening.
- 2) **Standardized Protocols for FIS.** There should be a standardized use of the current FIS positions. These positions are a valuable resource that should be targeted for children at risk for immediate removal or who have been removed. Each circuit should incorporate protocols for the use of Family Intervention Specialists in their Family Preservation Protocols and engage case management and treatment providers in the development of those protocols. Reasonable FIS caseloads should be established, with a focus on engaging families in assessments and initial treatment. Priority should be given to assessing families during the investigations phase. The FIS should assist CPIs with helping families become motivated for treatment. FIS should assist CPIs in determining when court-ordered services are an appropriate means for achieving parental participation in treatment. Level of care treatment recommendations for parents should consider the level of risk to child safety.
- 3) **Clear policy and protocol for case transfer.** There should be standardized guidelines relative to case transfer expectations from CPI to CBCs. These expectations should include:

- Identification of initial family barriers to receiving treatment. This includes an assessment of significant other persons (spouse or paramour) whose own use of alcohol or drugs may sabotage treatment efforts. Such information needs to be clearly conveyed to the treatment assessor, provider and case manager. Standardizing referral forms (from CPIs and case managers to CPIs and treatment agencies), results of FIS assessments, and treatment progress reporting should be implemented in every circuit.
 - Formal communication protocols for sharing information, developing case plans, staffing and monitoring cases for progress, and responding to situations such as relapse or failure to follow through with case plan requirements should be developed among CPI, case management, FIS, and service provider staff.
 - CPIs are required by the federal Child Abuse Prevention and Treatment Act (CAPTA) to refer children under the age of three who are involved in a substantiated case of child abuse and neglect to receive early intervention services. Children of parents with substance abuse disorders need to be evaluated and treated for the possible developmental impacts of alcohol or drug abuse. If these evaluations were not completed by the CPI during the assessment of child safety, they should be recommended by the CPI for Case Management follow-up, and referral for developmental assessments and early intervention services if indicated
 - Clear agreement as to caregiver participation in treatment and follow-up actions that will occur if the parent does not begin treatment program. Agreements should include who will provide weekly family contact to determine treatment participation.
- 4.) Required Training Related to Substance Abuse, Mental Health and Domestic Violence. Pre-service and in-service training of child welfare staff must include training on substance abuse, mental health and domestic violence. The Family Safety office has developed an integration of services training curriculum that has not been incorporated into existing training curricula.
- 5.) There are positive examples of how FISs are being utilized in various circuits around the state (Circuits 7, 11, 14). Opportunities to share promising practices within the state need to be provided.
- 6.) Incorporate specific case reviews of parents with substance use disorders in the department's and CBC lead agencies' quality assurance processes to identify opportunities for improvement in engaging families in case management and treatment services. Case reviews should engage FIS and treatment agency staff in the review process.
- 7.) Complete as soon as possible the FSFN/SAMHIS Data Integration Project. This will enhance information sharing at the case work level, and allow systems analysis at both the circuit and state levels of the number of parents in the child welfare system who are accessing and completing substance abuse and mental health services.

ⁱ U.S.Department of Health and Human Services (2004) *Child Maltreatment 2002*. Washington, D.C. U.S. Government Printing Office

ⁱⁱ Boles, S. (2011). Data analysis of the 2009 Adoption and Foster Care Analysis and Reporting System (AFCARS) data set. Unpublished data.

ⁱⁱⁱ Wulczyn F., Ernst, M. & Fisher, P. (2011). *Who Are the Infants in Out-of-Home Care? An Epidemiological and Developmental Snapshot*. Chicago: Chapin Hall at the University of Chicago

^{iv} U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

^v *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services With Child Welfare* Young, N.K. and Gardner, S.L., SAMHSA Publication No. SMA-02-3639, Rockville MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. (2002)

^{vi} *Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)*. DHHS Pub. NO. (SMA) 07-4261. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007.

^{vii} *Florida Department of Children and Families, Family Safety Program, Review of Substance Abuse and Mental Health Screening and Assessment Tools/Protocols*, DeCerchio, K. March, 2010.

^{viii} See number iii.