

**The Florida Senate**  
**BILL ANALYSIS AND FISCAL IMPACT STATEMENT**

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

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Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

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BILL: SPB 7078

INTRODUCER: For consideration by the Children, Families, and Elder Affairs Committee

SUBJECT: Child Welfare

DATE: March 31, 2015

REVISED: \_\_\_\_\_

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ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Preston	Hendon		<b>Pre-meeting</b>

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**I. Summary:**

Last year, the Legislature passed SB 1666, a major reform of the child welfare system. Among its many provisions, SB 1666:

- Created the Critical Incident Rapid Response Team (CIRRT) to conduct a root-cause analysis of certain child deaths and critical incidents,
- Expanded the number and types of cases reviewed through the Child Abuse Death Review (CADR) process,
- Required multi-agency staffings for cases alleging medical neglect, and
- Created the Florida Institute for Child Welfare (FICW), requiring it to submit an interim report by February 1, 2015.

SPB 7078 addresses issues related to the implementation of SB 1666.

To address the increased volume of cases reviewed through the CADR process and to better align it with the newly created CIRRT process, the SPB clarifies the roles of the two types of committees within the CADR process and imposes specific reporting requirements. The SPB also permits the Secretary of DCF to deploy CIRRTs in response to other child deaths in addition to those with verified abuse and neglect in the last 12 months. The SPB also requires more frequent reviews and reports by the CIRRT advisory committee.

The bill also requires a multi-agency staffing to be convened for cases of alleged medical neglect, clarifying that the staffing shall be convened only if medical neglect is substantiated by the child protection team.

The bill implements FICW interim report recommendations by clarifying Legislative intent to prioritize evidence-based and trauma-informed services.

The bill does not have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2015.

## II. Present Situation:

SB 1666 was passed in 2014 in response to concerns about the number of deaths of children known to the child welfare system. SB 1666 made a number of changes to state law to improve the investigation of and subsequent response to allegations of abuse or neglect. Among those changes were the creation of the Critical Incident Rapid Response Team (CIRTT), expansion of the number and types of cases reviewed through the Child Abuse Death Review (CADR) process, and the creation of the Florida Institute for Child Welfare (FICW).

### Child Abuse Death Review

The state Child Abuse Death Review (CADR) is a statewide multidisciplinary, multiagency child abuse death assessment and prevention system. The CADR was initiated in 1999 in response to the death of Kayla McKean and legislative concern that, of the 80 children who died from substantiated child abuse or neglect in Florida during 1998, almost one third (32 percent) had prior contact with the child protection system.

The purposes of CADR reviews are to:

- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse;
- Develop a communitywide approach to address such cases and contributing factors, whenever possible;
- Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse; and
- Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.

Florida's CADR is a two-tiered review system comprised of the State Child Abuse Death Review Committee and local review committees operating across the state. These committees work cooperatively to review the facts and circumstances surrounding child deaths that are reported through the central abuse hotline.

The State Child Abuse Death Review Committee is housed within the Department of Health (DOH) and consists of representatives from the Department of Health (DOH), the Department of Children and Families (DCF), the Department of Legal Affairs, the Department of Law Enforcement, the Department of Education, the Florida Prosecuting Attorneys Association, Inc., and the Florida Medical Examiners Commission, whose representative must be a forensic pathologist. In addition, the State Surgeon General must appoint the following members to the CADR:

- The Statewide Medical Director for Child Protection;
- A public health nurse;
- A mental health professional who treats children or adolescents;
- An employee of the DCF who supervises family services counselors and who has at least 5 years of experience in child protective investigations;
- A medical director of a child protection team;

- A member of a child advocacy organization;
- A social worker who has experience in working with victims and perpetrators of child abuse;
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program;
- A law enforcement officer who has at least 5 years of experience in children's issues;
- A representative of the Florida Coalition Against Domestic Violence; and
- A representative from a private provider of programs on preventing child abuse and neglect.

Local review committees have the primary responsibility of reviewing all child abuse and neglect deaths reported to the child abuse hotline and assisting the state committee in data collection and reporting. The local review committees are comprised of members determined by the state committee and a local state attorney. Statute requires no other staffing requirements or structure for the local review committee.

Prior to the passage of SB 1666, the CADR only reviewed child deaths verified to be the result of abuse or neglect. SB 1666 requires CADR to review all deaths reported to the central abuse hotline. This resulted in an increase in the number of deaths that must be reviewed through this process. For example, in calendar year 2014, 82 deaths were verified to be the result of abuse or neglect out of 440 total deaths reported to the hotline.

Current law establishes the State Child Abuse Death Review Committee and local child abuse death review committees within the Department of Health.<sup>1</sup> The committees must review the facts and circumstances of all deaths of children from birth through age 18 that occurred in Florida and are reported to the central abuse hotline of the Department of Children and Families.<sup>2</sup> The state committee must prepare an annual statistical report on the incidence and causes of death resulting from reported child abuse in the state. The report must include recommendations for:

- State and local action, including specific policy, procedural, regulatory, or statutory changes; and
- Any other recommended preventive action.<sup>3</sup>

The law provides the committees with broad access to any information related to the deceased child, or his or her family, that is necessary to carry out its duties, including:

- Medical, dental, or mental health treatment records;
- Records in the possession of a state agency or political subdivision; and
- Records of law enforcement which are not part of an active investigation.<sup>4</sup>

Records typically obtained by the committees include, among others: death and birth certificates; medical examiner report; law enforcement report; criminal history reports; first responder

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<sup>1</sup> Section 383.402, F.S.

<sup>2</sup> Section 383.402(1), F.S.

<sup>3</sup> Section 383.402(3)(c), F.S.

<sup>4</sup> Section 383.412(8) & (9), F.S.

reports; physician, hospital, and/or substance abuse and mental health records; and the Department of Children and Families case file.<sup>5</sup>

### **Critical Incident Rapid Response Team**

The Critical Incident Rapid Response Team (CIRRT) process involves an immediate root-cause analysis of critical incidents to rapidly determine the need to change policies and practices related to child protection and welfare. The DCF is required to conduct CIRRT reviews of child deaths if the child or another child in the home was the subject of a verified report of abuse or neglect within the previous 12 months. The DCF is authorized to deploy CIRRT's for other serious incidents reported to the central abuse hotline.

Statute requires that the CIRRT include at least five professionals with expertise in child protection, child welfare, and organizational management. A majority of the team must reside in judicial circuits outside the location of the incident.

An advisory committee of experts in child protection and welfare is tasked with meeting annually to conduct an independent review of the CIRRT reviews and submit an annual report which includes findings and recommendations.

The CIRRTs have been deployed 11 times since 2014. The types of deaths reviewed by CIRRT were caused by inflicted trauma, unsafe sleep, natural causes, and a dog mauling. CIRRT reports have identified issues with process and policies. These issues have prompted immediate changes such as updating the Maltreatment Index to allow for the presence of obvious mental health symptoms to be categorized as problematic and amending related protocol to facilitate immediate response priority for obvious mental health symptoms.

### **Medical Neglect**

While there is no definition of the term "medical neglect" in ch. 39, F.S., the definition of "neglect" encompasses cases of medical neglect. Neglect is defined as when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

Section 39.3068, F.S., requires that reports of alleged medical neglect be handled in a prescribed manner. It specifies that:

- Reports of medical neglect must be investigated by staff with specialized training in medical neglect and medically complex children.
- The investigation identifies any immediate medical needs of the child and uses a family-centered approach to assess the capacity of the family to meet those needs.

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<sup>5</sup> E-mail from Bryan Wendel, Office of Legislative Planning, Florida Dept. of Health, (August 25, 2014) (on file with the Senate Committee on Health Policy).

- Any investigation of cases involving medically complex children include determination of Medicaid coverage for needed services and coordination with AHCA to secure such covered services.
- A case staffing be convened and attended by staff from DCF's child protective investigations unit, Children's Legal Services, the child protection team, Children's Medical Services, the Agency for Health Care Administration, the community-based care lead agency, and any providers of services to the child.

Currently, the statutory language requires that a multiagency staffing occur on any case that alleges medical neglect, whether or not the allegation was substantiated as medical neglect by the child protection team.

### **Community Based Care Organizations**

The DCF contracts for foster care and related services with lead agencies, also known as community-based care organizations (CBCs). The transition to outsourced provision of child welfare services was intended to increase local community ownership of service delivery and design.

Under this localized system, CBCs are responsible for providing foster care and related services. These services include, but are not limited to, family preservation, emergency shelter, and adoption. CBCs contract with a number of subcontractors for case management and direct care services to children and their families. There are 18 CBCs statewide, which together serve the state's 20 judicial circuits. The law requires DCF to contract with CBCs through a competitive procurement process.

Even under this outsourced system, DCF remains responsible for a number of child welfare functions. These functions include operating the abuse hotline, performing child protective investigations (which determine whether children need to be removed from their homes because of abuse or neglect), and providing child welfare legal services. The DCF is also ultimately responsible for program oversight and the overall performance of the child welfare system.

Each month CBCs are graded by DCF according to their performance on a scorecard. The scorecard evaluates the CBCs on 12 key measures to determine how well the CBCs are meeting the most critical needs of these at-risk children and families. Scorecards are posted online monthly.

Currently, under this privatized care model, many services are provided through contracts with subcontracted service providers. Statute requires the services provided by these contracted entities to be supported by research or be considered best child welfare practices. The statute allows for innovative services such as family-centered, cognitive-behavioral, and trauma-informed.

### **Florida Institute for Child Welfare**

The Florida Institute for Child Welfare (FICW) was created by SB 1666 as a consortium of the state's public and private university schools of social work to advance the well-being of children

and families by improving the performance of child protection and child welfare services through research, policy, analysis, evaluation, and leadership development. The FICW is required to submit an annual report that presents significant research findings and results of other programs, and make specific recommendations for improving child protection and child welfare services.

The FICW submitted an interim report on February 1, 2015, in accordance with statute. The report addressed topics including recommendations for the need for a child welfare strategic plan, results oriented accountability, data analytics, safety, permanency, well-being, workforce, and the CIRRT. Most of the interim report's recommendations can be implemented without further statutory authorization. However, statutory changes are needed to implement recommendations that the frequency of the CIRRT advisory committee's reviews increase from annually to quarterly and that evidence-based and trauma-informed services be prioritized in statute.

### **Trauma-Informed Practice**

The FICW interim report recommended that evidence-based and trauma-informed practices be prioritized in statute. Children in the child welfare system have often suffered tremendous trauma due to abuse or neglect. This trauma can have a lifelong effect on their physical and mental health, education, relationships, and social function. To provide trauma-informed care to children, youth, and families involved with the child welfare system, professionals must understand the impact of trauma on child development and learn how to effectively minimize its effects without causing additional trauma. Untreated child trauma is a root cause of many of the most pressing problems that communities face, including poverty, crime, low academic achievement, addiction, mental health problems, and poor health outcomes. There are evidence-based treatments and services developed that are highly effective for child traumatic stress; improving access to effective evidence-based treatments for children who experience traumatic stress can reduce suffering and decrease the costs of health care.

## **III. Effect of Proposed Changes:**

### **Child Abuse Death Review**

The bill revises the CADR process in several ways. The bill amends s. 383.3068, F.S., to clarify the intent of the Legislature, specifying the data-based, epidemiological focus of the child abuse death assessment and prevention system as well as clarifying the cooperative roles of the two committees.

### **State Committee**

The bill clarifies that the state committee shall provide direction and leadership of the review system, analyze the data and recommendations of the local committees, identify issues and trends within that data and make recommendations for statewide action. The bill also adds a substance abuse treatment professional to the state committee, and limits the number of appointments a member may serve to no more than three consecutive terms.

### **Local Committee**

The bill clarifies that the local committee shall conduct individual case reviews, generate information for the state committee, and recommend and implement improvements at the local level. The bill specifies that local committee membership shall include representatives from:

- The local state attorney's office;
- The local DCF child protective investigations unit;
- The DOH child protection team;
- The local CBC;
- Law enforcement;
- The school district;
- A mental health treatment provider;
- A certified domestic violence center;
- A substance abuse treatment provider; and
- Any other members determined by guidelines developed by the state committee.

The bill also requires, to the extent possible, that the individuals involved with a child whose death is being reviewed should be present at the review. It also specifies that reports by local committees contain certain information, such as any systemic issues identified and recommendations for improvement.

### **Data and Report**

The bill requires the use of the Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths. It also specifies that the data in the annual state committee report must be presented on an individual calendar year basis and in the context of a multi-year trend.

The report must include:

- Descriptive statistics;
- A detailed analysis of the incidence and causes of death;
- Specific issues identified in current policy, procedure, regulation or statute and recommendations to address them from both the state and local committees; and
- Other recommendations to prevent deaths from child abuse based on the reported data.

### **Critical Incident Rapid Response Team**

The bill amends s. 39.2015, F.S., to allow a CIRRT to be deployed, at the secretary's discretion, for other child deaths besides those with a verified report of abuse or neglect in the last 12 months, to include those where there was an open investigation. The bill also requires the CIRRT advisory committee to meet quarterly and submit quarterly reports. This will allow more rapid identification of and response to trends surfaced through the CIRRT process.

### **Medical Neglect**

The bill amends s. 39.3068, F.S., and requires a multi-agency staffing to be convened for cases of alleged medical neglect, clarifying that the staffing shall be convened only if medical neglect is substantiated by the child protection team.

### **Community-Based Care Organizations**

The bill amends s. 409.986, F.S., to clarify legislative intent that CBC's prioritize use of evidence-based and trauma-informed services. The bill also amends s. 409.988, F.S., to require use of trauma-informed services by CBC's.

The bill provides an effective date of July 1, 2015.

#### **IV. Constitutional Issues:**

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

#### **V. Fiscal Impact Statement:**

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Requiring trauma-informed services may necessitate CBC's amending contracts with subcontractors providing direct services to children to include this requirement, if their contracts do not currently do so. SPB 7078 does not provide a definition of "trauma-informed."

C. Government Sector Impact:

#### **VI. Technical Deficiencies:**

None.

#### **VII. Related Issues:**

None.



**VIII. Statutes Affected:**

This bill amends the following sections of the Florida Statutes: 39.205, 39.3068, 383.402, and 409.988,

**IX. Additional Information:**

A. **Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. **Amendments:**

None.

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This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

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