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.)

Prepared By: The Professional Staff of the Committee on Fiscal Policy

BILL:	SB 7078
INTRODUCER:	Children, Families, and Elder Affairs Committee
SUBJECT:	Child Welfare
DATE:	April 17, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	Preston	Hendon		**CF Submitted as Committee Bill**
1.	Pace	Hrdlicka	FP	**Pre-Meeting**

I. Summary:

SPB 7078 addresses issues related to the child welfare system. Specifically, the bill:

- Clarifies the roles of the state and local review committees within the Child Abuse Death Review (CADR) process and imposes specific reporting requirements to address the increased volume of cases reviewed through the CADR process and better align it with the newly created Critical Incident Rapid Response Team (CIRRT) process;
- Permits the Secretary of Department of Children and Families (DCF) to deploy CIRRTs in response to other child deaths in addition to those with verified abuse and neglect in the last 12 months;
- Requires more frequent reviews and reports by the CIRRT advisory committee;
- 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; and
- Implements Florida Institute for Child Welfare (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.

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.[1] SB 1666 made a number of changes to state law to improve the investigation of and subsequent response to allegations of abuse or neglect.[2] Among those changes were the creation of the Critical Incident Rapid Response Team (CIRTT), expansion of

[1] Senate Children, Families, and Elder Affairs Committee, *Bill Analysis SB 1666*, (March 12, 2014), available at http://www.flsenate.gov/Session/Bill/2014/1666/Analyses/2014s1666.cf.PDF (last visited April 16, 2015).
[2] Chapter 2014-224, L.O.F.

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.[3] 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.[4]

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.[5]

The State Child Abuse Death Review Committee is housed within the Department of Health (DOH) and consists of representatives from the 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.[6]

[3] Section 383.402(1), F.S.
[4] Id.
[5] The committees review the deaths of all children from birth through age 18 that occurred in Florida.
[6] Section 383.402(2)(a) and (b), F.S.

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.[7] Statute requires no other staffing requirements or structure for the local review committee.

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.[8]

Currently, child abuse review committees have broad access to any information related to the deceased child, or his or her family, that is necessary to carry out their 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.[9]

Records typically obtained by the committees include, among others: death and birth certificates; medical examiner reports; law enforcement reports; criminal history reports; first responder reports; physician, hospital, and substance abuse and mental health records; and the DCF case file.[10]

Critical Incident Rapid Response Team

The 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 investigations 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. At the discretion of the secretary a CIRRT investigation may be initiated for other cases involving serious injury to a child.[11]

Each CIRRT must include at least five professionals with expertise in child protection, child welfare, and organizational management.[12] The types of deaths investigated by a CIRRT are accidental or inflicted trauma, unsafe sleep, natural causes, drowning, sudden infant death syndrome, and other causes under investigation.[13]

---

[7] Section 383.402(6) and (7), F.S.
[8] Section 383.402(3)(c), F.S.
[9] Section 383.402(8) and (9), F.S.
[10] 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).
[11] Section 39.2015(2), F.S.
[12] Section 39.2015(3), F.S.
[13] Department of Children and Families, *Statewide Data (2015),* available at http://www.dcf.state.fl.us/childfatality/state.shtml (last visited April 16, 2015).

An advisory committee of experts in child protection and welfare is tasked with meeting annually to conduct an independent review of the CIRRT investigations and submit an annual report to the Governor and the Legislature that includes findings and recommendations.[14] 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

Section 39.3068, F.S., requires that reports of alleged medical neglect[15] be handled in a prescribed manner:

- 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;
- Any investigation of cases involving medically complex children include determination of Medicaid coverage for needed services and coordination with Agency for Health Care Administration (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 AHCA, the community-based care lead agency, and any providers of services to the child.[16]

Currently, a multiagency staffing must occur on any case that alleges medical neglect, whether or not the allegation was substantiated as medical neglect by the child protection team.[17]

Community Based Care Organizations

The DCF contracts for foster care and related services with lead agencies, also known as community-based care organizations (CBCs).[18] The transition to outsourced provision of child welfare services was intended to increase local community ownership of service delivery and design. CBCs are responsible for providing foster care and related services including:

- Family preservation;
- Emergency shelter; and
- Adoption.

[14] Section 39.2015(11), F.S.
[15] 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.
[16] Section 39.3068, F.S.
[17] Section 39.3068(3), F.S.
[18] Section 409.986(1), F.S.

Under the CBC model, many services are provided through contracts with subcontracted service providers. Currently, the services provided by these contracted entities must 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 interventions designed to mitigate out-of-home placements.[19]

Florida Institute for Child Welfare

The Florida Institute for Child Welfare (FICW), within the Florida State University College of Social Work[20] was created 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 institute consists of a consortium of public and private universities offering degrees in social work.[21] 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.[22]

Trauma-Informed Practice

The FICW's 2015 interim report[23] 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.

Currently, CBCs are not required to implement trauma informed services.

III. Effect of Proposed Changes:

Child Abuse Death Review

The bill amends s. 383.402, 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 state and local child abuse death review committees.

---

[19] Section 409.988(3), F.S.
[20] Florida State University College of Social Work, *Florida Institute for Child Welfare*, available at http://csw.fsu.edu/ficw/ (last visited April 16, 2015).
[21] Section 1004.615(1), F.S.
[22] Section 1004.615(6), F.S.
[23] Florida Institute for Child Welfare, Interim Report (2015), available at http://csw.fsu.edu/wp-content/uploads/2015_FICW_InterimReport.pdf (last visited April 16, 2015).

State Child Abuse Death Review Committee

The bill clarifies that the primary function of the state review committee is to provide direction and leadership for the review system and to analyze data and recommendations from local review committees to identify issues and trends and to recommend statewide action.

The bill also revises the composition of the state child abuse death review committee to add a substance abuse treatment professional to the committee membership and limits the number of appointments a member may serve to no more than 3 consecutive terms.

The bill requires the committee to develop statewide uniform guidelines, standards and protocols, including a protocol for standardized data collection and reporting for local child abuse death review committees. The committee must also develop statewide uniform guidelines for reviewing deaths that are the result of child abuse.

The bill requires the state review committee to provide an annual statistical report to the Governor and the Legislature. The data in the annual report must be presented on an individual calendar year basis and in the context of a multi-year trend and must include:

- Descriptive statistics;
- A detailed analysis of incidences 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.

Local Death Review Committee

The bill clarifies that the primary function of the local review committee is to conduct individual case reviews of deaths, generate information for the state committee, make recommendations, and implement improvements at the local level. The bill repeals the requirement that the local committee be convened by agreement between the State Surgeon General, the director of each county health department, or the directors of two or more county health departments. Instead, the bill authorizes the State Surgeon General to convene the committee.

The bill specifies that the local committee membership include representatives from:

- The local state attorney's office;
- The local DCF child protective investigations unit;
- The DOH child protection team;
- The medical examiner's office;
- 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 verified as caused by abuse or neglect must attend meetings where the child's case is reviewed.

The bill modifies the reporting requirements of the local committee to include of any systemic issues identified through the review process and recommendations for system improvements and needed resources, training, and information dissemination, where gaps and deficiencies may exist.

Data Collection

The bill revises the duties of the state child abuse death committee to include the development of a system for collecting data from local committees on deaths that are reported to the central abuse hotline. 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 by both the state and local review committee. The bill also clarifies that the committees may only share *with each other* any relevant information that pertains to the review of the death of a child. Currently, the committees may share any relevant information that pertains to the review of the death of a child.

The bill makes other clarifying and editorial changes in regard to the roles and responsibilities of the DOH and DCF in child abuse death reviews.

Critical Incident Rapid Response Team

The bill amends s. 39.2015(2), F.S., to allow a CIRRT to be deployed, at the secretary's discretion, for other cases involving *child deaths, including but not limited to, a death or serious injury occurring during an open investigation*. Currently, a CIRRT can be deployed at the secretary's discretion for other cases involving *serious injury to a child*. The purpose of the investigation is to identify root causes and rapidly determine the need to change policies and practices related to child protection and welfare.

The bill also requires the CIRRT advisory committee to meet quarterly and submit quarterly reports, instead of once annually. This change will allow more rapid identification of and response to information acquired through the CIRRT process.

Reports of Medical Neglect

The bill amends s. 39.3068(3), F.S., to require 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. Currently, the department convenes the multi-agency staffing *after the receipt of the report* from the child protection team.

Community-Based Care Organizations

The bill amends s. 409.986(1)(a), F.S., to clarify the legislative intent that CBCs prioritize use of evidence-based and trauma-informed services. The bill also amends s. 409.988(3), F.S., to require use of evidenced-based trauma-informed best practices by CBCs.

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 evidenced-based trauma-informed services may necessitate CBCs 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:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 39.2015, 39.3068, 383.402, 409.986, 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.