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 Children, Families, and Elder Affairs

BILL:	PCS/SB 122 (309750)
INTRODUCER:	Committee on Children, Families, and Elder Affairs
SUBJECT:	Child Welfare
DATE:	December 9, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

The PCS/SB 122 is titled "Jordan's Law" and makes a number of changes to the laws related to the child welfare system in an attempt to address issues that were identified in the case of Jordan Belliveau, a two-year old boy who was killed by his mother in Pinellas County.

The PCS requires specified child welfare professionals, guardians ad litem, and law enforcement officers to receive training developed by the Department of Health on the recognition of and response to head trauma and brain injury in children under six years old.

The PCS also:

- Removes all training for the child welfare workforce from the community-based care lead agencies (CBCs) and standardizes it statewide by requiring the Department of Children and Families (DCF or department) to return to the professional development center model that worked successfully for 25 years.
- Requires the department in conjunction with the Florida Institute for Child Welfare (institute) to develop and implement a comprehensive uniform child welfare workforce framework based on a nationally recognized model and specifies issues to be addressed.
- Consolidates and eliminates requirements related to education and training which would be encompassed into or become unnecessary as a result of development of a new framework.
- Eliminates the requirements for child welfare staff related to third party credentialing entities.
- Revises the mission of the Florida Institute for Child Welfare to one focused on education, training, and well-being and other support for the child welfare workforce.

The PCS is not expected to have a significant fiscal impact due to existing resources that will be able to be redirected to the revised training and education requirements and takes effect July 1, 2020.

II. Present Situation:

Jordan Belliveau

Jordan Belliveau, Jr., was killed by his mother in September 2018 when he was two years old. At the time of his death, the family was under court-ordered protective supervision as Jordan, who had been removed from his parent's custody in October 2016, was reunified with his mother, 21-year old Charisee Stinson, in May 2018. In addition to the open service case, there was also an active child abuse investigation due to ongoing domestic violence between his mother and father, 22-year-old Jordan Belliveau, Sr.

Due to lack of communication to the court, lack of communication between the Pinellas County Sheriff's Office and the DCF, and lack of evidence provided by Directions for Living, the contracted case management organization for Eckerd Connects, the community-based care lead agency, regarding the parent's case plan compliance, ongoing family issues that created an unsafe home environment for Jordan were never addressed. Jordan was initially reported missing by his mother in September 2018 and a statewide Amber Alert was issued. His body was found by law enforcement four days after his death. His mother was charged with aggravated child abuse and first-degree murder. His mother admitted to killing Jordan by hitting him, which caused the back of his head to hit a wall in their home.

Special Review of the Case Involving Jordan Belliveau Jr.

Case Summary

Given the circumstances of the case, former Interim Secretary Rebecca Kapusta immediately initiated a special review to evaluate the circumstances surrounding Jordan's death and to assess the services provided during the 17 months he remained removed from the home and continuing upon his reunification with his mother in May 2018. The multidisciplinary team was not only comprised of individuals who specialize in child welfare, but also those with mental health, and domestic violence expertise (both from a treatment and law enforcement perspective) to address the reunification decision and actions that occurred when subsequent concerns were identified.[1]

Jordan's family first came in contact with the DCF in October 2016 when a report was made to the hotline alleging Jordan was in an unsafe home environment that included gang violence. Jordan was placed in foster care after his mother was unable to obtain alternative housing. He was subsequently adjudicated dependent on November 1, 2016, and placed in foster care. His parents were offered a case plan with tasks including finding stable housing and receiving mental health services and counseling.

Throughout Jordan's case, his mother and father were either non-compliant or only partially compliant with their case plans. Nevertheless, due to lack of communication to the court and lack of evidence provided by the case management organization, Directions for Living, regarding compliance, Jordan was eventually reunified with his mother and father. After reunification and

[1] Department of Children and Families, *Special Review of the Case Involving Jordan Belliveau, Jr*. (Jan. 11, 2019), available at http://www.dcf.state.fl.us/newsroom/docs/Belliveau%20Special%20Review%202018-632408.pdf . (Last visited November 15, 2019).

while still under judicial supervision, domestic violence continued between the parents, with Jordan's father being arrested for domestic violence against Jordan's mother in July 2018. However, the incident was not immediately reported to the hotline upon his arrest, and thus the incident was not reported to the court at a hearing the next day regarding Jordan's reunification.

When the incident was reported to the hotline three weeks later, a child protective investigation was conducted by the Pinellas County Sheriff's Office. However, the investigator determined that Jordan was not currently in danger, and therefore, found there was no need to remove him from the home. Given the ongoing and escalating level of violence between the parents, the inability to control the situation in the home, and the risk of harm posed to Jordan should his parent engage in further altercations, an unsafe home environment should have been identified.

However, with no concerns for Jordan's safety raised after the investigation or during subsequent hearings, there was no consideration for an emergency modification of his placement and Jordan was reunited with his father. On August 31, 2018, a case manager visited Jordan's parents to discuss several issues regarding lack of cooperation with the Guardian ad Litem and case plan tasks. The case manager emphasized the continued need for Jordan's parents to participate in services or risk losing custody of Jordan. Less than 24 hours after the visit, Jordan was reported missing by his mother. Four days later his body was found. Jordan's mother admitted to killing him by hitting him in a "moment of frustration" which "in turn caused the back of his head to strike an interior wall of her home."[2]

Findings in the Report

- The decision to reunify Jordan was driven primarily by the parents' perceived compliance to case plan tasks and not behavioral change. There was a noted inability by all parties involved to recognize and address additional concerns that became evident throughout the life of the case. Instead, case decisions were solely focused on mitigating the environmental reasons Jordan came into care and failed to address the overall family conditions.
- Following reunification, policies and procedures to ensure child safety and wellbeing were not followed. In addition, Directions for Living case management staff did not take action on the mother's lack of compliance and her failure to participate with the reunification program prior to and following reunification.
- When the new child abuse report was received in August 2018, alleging increased volatility between the parents, present danger was not appropriately assessed and identified. The assessment by the Pinellas County Sheriff's child protective investigator (CPI) was based solely on the fact that the incident wasn't reported to the hotline when it initially occurred. The CPI failed to identify the active danger threats occurring within the household that were significant, immediate, and clearly observable. Given the circumstances, a modification of Jordan's placement should have been considered.
- Despite the benefit of co-location, there was a noted lack of communication and collaboration between the Pinellas County Sheriff's Office CPID unit and Directions for Living case management staff in shared cases involving Jordan and his family, especially regarding the August 2018 child abuse investigation.

[2] *Id*.

- In addition to the lack of communication and collaboration between frontline investigations and case management staff noted above, there was an absence of shared ownership between all entities involved throughout the life of Jordan's case which demonstrates a divided system of care. In addition, the lack of multidisciplinary team approach resulted in an inability to adequately address the identified concerns independent of one another.
- The biopsychosocial assessments failed to consider the history and information provided by the parents and resulted in treatment plans that were ineffective to address behavioral change. Moreover, there was an over-reliance on the findings of the biopsychosocial assessments as to whether focused evaluations were warranted (e.g., substance abuse, mental health, domestic violence, etc.), despite the abundance of information to support such evaluations were necessary.[3]

Conclusion

The report's findings and conclusion do not indicate that Jordan's death was the result of any shortcomings or loopholes in the law or lack of training related to the identification of brain injury, but rather due to the multiple failures of individuals working with children in the child welfare system to communicate, coordinate and cooperate:

> Complex child welfare cases are difficult enough when high caseloads and continual staff turnover plague an agency. However, it is further impacted when those involved in the case (protective investigations, case management, clinical providers, legal, Guardians ad Litem, and the judiciary) fail to work together to ensure the best decisions are being made on behalf of the child and their family.
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> This case highlights the fractured system of care in Circuit 6, Pinellas County, with each of the various parts of the system operating independently of one another, without regard or respect as to the role their part plays in the overall child welfare system. Until the pieces of the local child welfare system are made whole, decision-making will continue to be fragmented and based on isolated views of a multi-faceted situation.[4]

Current Brain Injury Training Requirements

Currently, all case managers, Guardian ad Litem staff and volunteers, dependency court judges, child protective investigators and supervisors, Children's Legal Services' attorneys, and law enforcement officers are required to complete required training for their position. Typically, this is done as preservice and continuing education training. None of the required training includes the recognition of and response to head trauma and brain injury in a child under age six.[5]

[3] *Id.*
[4] *Id*.
[5] For specific training requirements see ss. 25.385, 39.8296, 402.402, 409.988, 943.13 and 943.135, F.S.

Education and Training Requirements for Child Welfare Staff

Training and Certification

In 1986, the Legislature required the Department of Health and Rehabilitative Services (HRS) to establish, maintain and oversee the operation of child welfare training academies in the state for the expressed purpose of enabling the state to provide a systematic approach to staff development and training for dependency program staff. The legislature further intended that this approach to training would aid in the reduction of poor staff morale and of staff turnover, positively impact the quality of decisions made regarding child and families and afford a better quality of care for children placed in out-of-home care.[6] The HRS established a number of training academies statewide that were widely recognized as a national model for child welfare workforce training.

In 2000, the Legislature authorized the department to create certification programs for its employees and service providers to ensure that only qualified employees and service providers provide client services. The department was authorized to develop rules that included qualifications for certification, including training and testing requirements, continuing education requirements for ongoing certification, and decertification procedures to be used to determine when an individual no longer meets the qualifications for certification and to implement the decertification of an employee or agent.[7] The department subsequently developed 11 types of certification designations for child protection professionals.

In 2011, at the urging of the CBCs, the Legislature eliminated the department's child welfare training program and removed the department's ability to create certification programs.[8]

Education

The college degrees most tailored to and associated with child welfare are the bachelor's and master's degrees in social work. During the first half of the 20th century, the federal government, in cooperation with universities and local agencies, established a child welfare system staffed by individuals with professional social work educations. Child welfare came to be viewed as a prestigious specialty within the social work profession.

In the 1990's, an increased recognition of child abuse led to enactment of state child abuse and neglect reporting laws and toll-free numbers to report abuse. This resulted in a large increase of child abuse reports, and resources for the preparation and support of additional staff needed to respond to the reports became inadequate. States moved quickly to hire additional employees to investigate abuse. One way to expand the workforce was to reduce staff qualifications. In response to having a varied workforce without similar expertise and training, agencies began to structure child welfare work to reduce its complexity and make it possible for people with fewer qualifications to adequately perform required tasks.

[6] Chapter 86-220, L.O.F. The first training academy was required to be operational by June 30, 1987 and be located at Tallahassee Community College.
[7] HB 2125, Chapter 2000-139. L.O.F.
[8] HB 279, Chapter 2011-163, L.O.F.

Several studies have found evidence that social work education, at either the bachelors of social work (BSW) or masters of social work (MSW) level, positively correlates with performance. A study conducted in Maryland public child welfare agencies found an MSW to be the best predictor of overall performance as measured by supervisory ratings and employee reports of work related competencies. A national study that measured competencies related to 32 job-related duties found that both MSW and BSW staff were better prepared for child welfare work than their colleagues without social work education.[9]

Research conducted with staff in Kentucky's public child welfare agency also revealed that staff with social work degrees scored significantly better on state merit examinations, received somewhat higher ratings from their supervisors, and had higher levels of work commitment than other staff. A Nevada study showed that caseworkers who had a social work degree were significantly more likely to create a permanent plan for children in their caseloads within three years than their colleagues without social work education.[10]

In 2014, the Legislature required the department to set a goal of having at last half of all child protective investigators and supervisor's with a bachelor's degree or a master's degree in social work from a college or university social work program accredited by the Council on Social Work Education. Despite numerous studies and reports supporting the value of a formal social work education in child welfare, Florida has made little if any progress towards re-professionalizing the workforce. In fact, the state has seen a decline since 2016.

Percentage of Child Protective Investigative Positions With Social Work Degree			
	BSW	MSW	Either
2014			9.5%
2016	12%	3%	
2019	11%	2%	

Reciprocal Peer Support and Other Supports for Child Welfare Staff Well-Being

Finding ways to support staff, outside of traditional supervisory channels, is now common in many fields. In recognition of the power of collegial relationships and trust, child welfare agencies have been exploring opportunities for doing this in recent years. The National Center for Trauma-Informed Care defines peer support as "a flexible approach to building healing relationships among equals, based on a core set of values & principles." The practices are rooted in the research that shows people who share common experiences are best able to empathize with one another as well as offer each other the benefit of their own learning.[11]

Several New England states have been developing models for peer support, with New Jersey's comprehensive Worker2Worker model being the most widely known. The model is grounded in

[9] The Florida Senate, Bill Analysis and Fiscal Impact Statement, SB 1666, March 12, 2014, available at: http://www.flsenate.gov/Session/Bill/2014/1666/Analyses/2014s1666.cf.PDF (Last visited November 30, 2019).
[10] *Id*.
[11] The New England Association of Child Welfare Commissioners and Directors and Casey Family Programs, Trauma-Informed Resilient Child Welfare Agencies: A New England Learning Community Summary of the Work, April 2017, available at: https://jbcc.harvard.edu/sites/default/files/ne_tircw_convenings.report.4.7.17_final.pdf (Last visited November 8, 2019).

the assumptions that staff are routinely exposed to stressful situations and that they constantly deal with trauma and stress both on and off the job.Worker2Worker is a confidential peer-counseling support helpline for Division of Child Protection and Permanency employees to help manage the unique stresses of their jobs. Worker2Worker is a 7-day-aweek helpline coordinated by Rutgers University Behavioral Health Care and staffed by former DCP&P supervisors and caseworkers. The helpline features a nationally recognized best practice model of peer support entitled "Reciprocal Peer Support," clinical care telephone assessments, resilience-building events, a network of referral/treatment services, and psychological first aid with crisis response services after traumatic events.[12]

New Jersey credits a uniform multi-faceted approach to workforce well-being including peer support, manageable caseload sizes, supervisory ratios, and enhanced training as being vital to greater job satisfaction and retention. The state enjoys a staff vacancy rate of 2.22%, a staff turnover rate of 8.91% and high staff tenure. Approximately half (47%) of the workforce have been employed by the state for more than ten years and more than two-thirds (69%) have been employed by the state for 6 or more years.[13]

Florida's child welfare system has no formalized system to support child protective investigation staff.

The Florida Institute for Child Welfare

In 2014, the Legislature established the Florida Institute for Child Welfare (FICW) at the Florida State University College of Social Work. The purpose of the FICW is 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.[14] The institute is required to:

- Maintain a program of research which contributes to scientific knowledge and informs both policy and practice;
- Advise the department and other organizations participating in the child protection and child welfare system regarding scientific evidence;
- Provide advice regarding management practices and administrative processes used by DCF
- and other organizations participating in the child protection and child welfare system and recommend improvements; and
- Assess the performance of child protection and child welfare services based on specific
- outcome measures.
- Evaluate the scope and effectiveness of preservice and inservice training for child protection and child welfare employees and advise and assist the department in efforts to improve such training.
- Assess the readiness of social work graduates to assume job responsibilities in the child protection and child welfare system and identify gaps in education which can be addressed through the modification of curricula or the establishment of industry certifications.

[12] Id.
[13] New Jersey Department of Children and Families WORKFORCE REPORT 2016-2017 Updates, available at: https://www.nj.gov/dcf/childdata/exitplan/NJ.DCF.Workforce.Report-FY17.pdf (Last visited November 6, 2019).
[14] Section 1004.615, F.S.

- Develop and maintain a program of professional support including training courses and consulting services that assist both individuals and organizations in implementing adaptive and resilient responses to workplace stress.
- Participate in the department's critical incident response team, assist in the preparation of reports about such incidents, and support the committee review of reports and development of recommendations.
- Identify effective policies and promising practices, including, but not limited to, innovations in coordination between entities participating in the child protection and child welfare system, data analytics, working with the local community, and management of human service organizations, and communicate these findings to the department and other organizations participating in the child protection and child welfare system.
- Develop a definition of a child or family at high risk of abuse or neglect. Such a definition must consider characteristics associated with a greater probability of abuse and neglect.[15]

III. Effect of Proposed Changes:

Section 1 provides a short title. The bill is titled "Jordan's Law" after Jordan Belliveau, a two-year old child in Florida's child welfare dependency system, who was killed by his mother in September 2018.

Section 2 amends s. 39.303, F.S., relating to Child Protection Teams, to require the Child Protection Teams to add information on the recognition of and response to head trauma and brain injury in children under six years old to currently mandated trainings developed for program and other employees of the department, employees of the Department of Health, and other medical professionals as is deemed appropriate to enable them to develop and maintain their professional skills and abilities in handling child abuse, abandonment, and neglect cases.

Section 3 amends s. 39.8296, F.S., relating to the statewide Guardian ad Litem Office, to require that training for guardians ad litem include information on the recognition of and responses to head trauma and brain injury in children under six years old that is developed by the Child Protection Team program.

Section 4 amends s. 402.40, F,S,, relating to child welfare training and certification, to:
- Remove all training for the child welfare workforce from the community-based care lead agencies and standardizes it statewide by requiring the department to return to the professional development center model that worked successfully for 25 years.
- Require the department in conjunction with the institute to develop and implement a comprehensive uniform child welfare workforce framework based on a nationally recognized model and specifies issues to be addressed.
- Consolidate and eliminate requirements related to education and training which would be encompassed into or become unnecessary as a result of development of a new framework.
- Eliminate the requirements related to third party credentialing entities.

Section 5 amends s. 409.988, F.S., relating to duties of community-based care lead agency duties, to require that training for all individuals providing care for dependent children include

[15] *Id*.

information on the recognition of and responses to head trauma and brain injury in children under six years old that is developed by the Child Protection Team program.

Section 6 creates s. 943.17298, F.S., relating to law enforcement training, to require that training for law enforcement officers include information on the recognition of and responses to head trauma and brain injury in children under six years old that is developed by the Child Protection Team program. Such training may either be a part of basic recruit training or continuing education or training.

Section 7 amends s. 1004.615, F.S., relating to the Florida Institute for Child Welfare, to revise the mission of the institute to one focused on education, training, and well-being and other support for the child welfare workforce and eliminate outdated reports.

Section 8 repeals s. 402.402, F.S., relating to child protection and child welfare personnel and attorneys employed by the department, to consolidate and eliminate requirements related to education and training which would be encompassed into or become unnecessary as a result of development of a new framework.

Section 9 amends s. 402.731, F.S., relating to third-party credentialing for child welfare personnel, to conform to changes made by the PCS.

Section 10 amends s. 409.996, F.S., relating to duties of the department, to conform to changes made by the PCS.

Section 11 amends s. 1009.25, F.S. relating to postsecondary fee exemptions, to conform to changes made by the PCS.

Section 12 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill would revise training and education functions of the Department of Health, the Department of Children and Families, and the Florida Institute for Child Welfare. The Department of Health currently develops training for the Child Protection Teams that investigate child abuse cases. Additional training on brain injuries in children would need to be developed. The cost of such training is unknown, but is not expected to be significant.

The bill requires the Department of Children and Families to contract for creation and operation of regional professional development centers in the state's universities and colleges. Currently federal Title IV-E funds are appropriated to the department and the community based lead agencies to train child welfare staff. These funds would be able to be redirected to pay for the regional professional development centers.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill substantially amends ss. 39.303, 39.8296, 402.40, 409.988, 1004.615, 402.731, 409.996 and 1009.25 of the Florida Statutes.
This bill creates 943.17298 of the Florida Statutes.
This bill repeals 402.402 of the Florida Statutes.

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.