Los Angeles County
Blue Ribbon Commission on Child Protection

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April 18, 2014

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

RE: FINAL REPORT OF THE BLUE RIBBON COMMISSION ON CHILD PROTECTION

Dear Supervisors:

The Blue Ribbon Commission on Child Protection is grateful to the Board for allowing us the opportunity to review the current child protection system and recommend substantial reforms. We appreciate that the Chief Executive Office has recognized the importance of child protection in its recently proposed budget and hope that a final budget will take into account the reforms proposed in the attached Final Report of the Commission.

As part of its review, we conducted 15 public hearings, interviewed more than 300 stakeholders across all program areas related to child safety, and consulted with child welfare experts from across the country. Commissioners committed to improving the lives of children have arrived at these recommendations after much input, serious thought, and vigorous discussion. We firmly believe that implementation of our recommendations will dramatically improve the safety, health, well-being, and life success of the children of Los Angeles County. It is our hope that the Board of Supervisors and all stakeholders in the system will agree and move forward with renewed spirit and urgency to make our children safe.

Sincerely,

Dr. David Sanders, Chair, Blue Ribbon Commission on Child Protection

Leslie Gilbert-Lurie, Vice Chair, Blue Ribbon Commission on Child Protection

Judge Dickran M. Tevrizian, Vice Chair, Blue Ribbon Commission on Child Protection

The Road to Safety for Our Children

Final Report of the Los Angeles County Blue Ribbon Commission on Child Protection

APRIL 18, 2014

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Los Angeles County
Blue Ribbon Commission on Child Protection

EXECUTIVE SUMMARY

I. BACKGROUND

We cannot stand idly by and wait for another child to meet the fate of Gabriel Fernandez.

Sparked by his and other tragic child fatalities, community outrage, and a series of unsuccessful attempts at reforming the County's child protection system, the Board of Supervisors agreed that action is necessary. Stating that "the current system does not serve the best interest of the child, the family, or the community at large," the Board of Supervisors (Board) established the Blue Ribbon Commission on Child Protection and charged it with reviewing child protection failures; highlighting organizational barriers to child-safety; and providing "recommendations for a feasible plan of action to expeditiously implement needed reforms."

As part of its review, the Commission conducted 15 public hearings, interviewed more than 300 stakeholders across all program areas related to child-safety, examined 28 child fatality cases, and researched promising practices across the country. Over the course of eight months, we heard stories of resilience, heroism, and commitment of youth, parents, social workers, and other first responders. We also heard from County leaders describing ideas and efforts to improve the current system.

At the same time, we heard testimony that some infants spend hours on the desks of social workers due to a shortage of foster homes and an inefficient placement process. Many children do not receive the minimally required monthly visits by caseworkers or have trusting relationships with them. Social workers testified that they were unable to perform essential functions because of overwhelming caseloads and insufficient support, supervision, and training. Similarly, judges confirmed that the judicial system operates under the burden of too many cases and, at times, incomplete or inaccurate information.

Repeatedly, the Commission heard testimony regarding inequitable funding systems and lack of support services for essential relative caregivers. A recurring theme in our hearings was that children, youth, parents, relatives, foster parents, and community groups, who should be at the center of planning, feel devalued and unheard.

The Commission unanimously concluded that a State of Emergency exists, which requires a fundamental transformation of the current child protection system. The greatest obstacle to reform is the County system itself. Key entities too often operate in silos, rather than as an integrated network with a shared commitment and vision. These include the Departments of Public Health, Mental Health, Health Services, Children and Family Services, Public Social Services, Housing, the Sheriff's Department, and Probation, as well as the Los Angeles County Office of Education, First 5 LA, and various commissions. Along with the Dependency Court, they should approach child protection in partnership, driven by an over-arching mission.

In its Final Report, the Commission seeks to give the Board of Supervisors a roadmap for creating an integrated, effective child safety system. It is a plan that includes prevention, collaboration, integration, measurement, oversight, and accountability. Most importantly, it calls for immediate system-wide transformation *and* a mechanism to ensure its implementation. Successful system-wide reforms have been accomplished in other jurisdictions with similar challenges, and it can be done in Los Angeles.

This Executive Summary provides a brief summary of the Commission's Final Report, along with highlights of some of our key recommendations. The importance of the recommendations, however, cannot fully be appreciated without a thorough reading of the Final Report itself.

II. IMMEDIATE ACTION BY THE BOARD OF SUPERVISORS

The basic tenets of the Commission's reform plan can be summarized in five essential actions by the Board: (1) articulate a county-wide mission to improve child-safety; (2) establish an entity to oversee one unified child protection system; (3) define measures of success and oversee the reform process; (4) adopt the Commission's Interim and Final Report recommendations; and (5) establish an Oversight Team to ensure their implementation.

1. Articulate a County-Wide Mission to Prioritize and Improve Child-Safety

Notwithstanding its commitment to addressing this problem, the Board has not expressly articulated a County-wide mission or philosophy with regard to the welfare of children. County entities that should collaborate in planning, funding programs, and providing services to effectively serve children generally fail to adequately communicate and coordinate efforts. In the absence of this common mission, the County, too often, has forfeited its ability to benefit from the sum of its parts.

The Board should mandate that child safety is a top priority and articulate a child-centered, family-focused, County-wide Mission that calls for:

- All relevant County entities to work together and with the community;
- Joint strategic planning and blended funding streams;
- Data-driven programs and evaluations;
- A comprehensive service delivery system, including prevention programs that stop child maltreatment before it starts; and

- An annual overview of the state of the field of child welfare, presented to the Board by external experts.

This mission should pave the way for a new system that values transparency in its practices, finances, and outcomes. It should ensure that the County is keenly attuned to the voices of those whom it is designed to serve. Participation from youth and from culturally diverse communities is essential. Department directors, as well as the CEO, should be selected and evaluated on their ability to achieve goals emanating from this mission. In short, there must be greater and clearer accountability.

2. Establish an Entity to Oversee One Unified Child Protection System

Previous attempts at sustainable child welfare reform have failed because no single entity is charged with and empowered to ensure an integrated approach to child protection. The absence of one leader overseeing a County-wide child welfare entity is a major impediment. Others have reached similar conclusions in the past. **It is critical that one entity be responsible and accountable for the well-being of the child as a whole and that this entity have no other competing responsibilities. This entity must have the authority to recommend to the Board movement of resources and staff across relevant County departments.**

The Board should establish a Los Angeles County Office of Child Protection (OCP), with County-wide authority to coordinate, plan, and implement one unified child protection system. The director of the entity would report directly to the Board and be held accountable for achieving agreed upon outcomes. The director must be vested with over-all responsibility for child protection in the County and, in part, should:

- Oversee a Joint Strategic Planning Process to create a comprehensive, child-centered strategic plan that is data driven, informed by best practices, connects all child welfare services in the County, and articulates measurable goals and time frames.
- Have clear oversight and authority over financial and staffing resources from all relevant departments, as delegated by the Board.
- Institute an annual County-wide budget review process that examines all proposed, present, and past resource allocations and align them with the goals of the County-wide strategic plan, as well as coordinate relevant funding streams from various departments.
- Serve as the repository of and review all recommendations related to the protection of children. Oversee implementation of appropriate recommendations, including those contained in the Final Report.
- Review existing County commissions and, with the Board, streamline them, as appropriate.
- Establish and evaluate measurable outcomes as part of the annual planning and budget allocation process to facilitate constant improvement, generalize successful and discontinue unsatisfactory practices.
- Oversee County-wide prevention efforts.

The director of this entity must have experience in leading change in complex organizations and have a passion for protecting children.

The Commission unanimously endorsed these goals and the requisite qualities of the director. The majority of the Commissioners voted to establish a Los Angeles County Office of Child Protection, which would report directly to the Board, as the best vehicle to bring about sustained comprehensive reform. The Commission recognizes that the Board may want to explore other approaches to accomplish this objective.

3. Define Measures of Success and Oversee the Reform Process

The Board should have a clear and consistent process of review. It should adopt clear outcome measures and ensure accountability by regular assessment of whether goals are being attained. Assessments should measure outcomes, such as the overall incidence of abuse, severe abuse, and neglect per capita by a geographic area; the recurrence of maltreatment within six months; and the number of child fatalities due to abuse or neglect.

4. Adopt the Commission's Interim Report Recommendations

On December 30, 2013, the Commission provided the Board with an Interim Report, comprised of ten recommendations capable of immediate implementation. These included strengthening the responses of law enforcement agencies and oversight by the District Attorney's Office; targeting more resources to children age five and under who are at highest risk of abuse; and strategically utilizing health services. Since the Interim Report was issued four months ago, another 5,000 referrals of child abuse and neglect have been investigated without the benefit of systemic reform. Each day we wait for reform, 40 more infants are reported as possible victims of abuse or neglect. The Final Report restates the Interim Report recommendations for law enforcement and health services, and adds new ones that are intrinsically related. The Commission recommends that these Interim Report and related recommendations be immediately adopted.

5. Establish an Oversight Team to Ensure Implementation of Recommendations

A critical missing component in previous attempts at child safety reform has been the absence of an empowered team capable of overseeing implementation of reforms. The Commission believes that the immediate establishment of an Oversight Team is essential to ensuring implementation of our recommendations while the broader structural changes are put in place. The importance of this team cannot be overstated. It will help the Board to fully realize its directives.

III. ADDITIONAL RECOMMENDATIONS TO ADDRESS THE STATE OF EMERGENCY

While the Commission has concluded that articulating a County-wide mission and creating an Office of Child Protection are the linchpins of successful systemic reform, other recommendations, when implemented, will immediately enhance child safety and well-being. The recommendations in the Final Report cover a wide range of departments and agencies, as well as issues including kinship care, education, social workers, and mental health. The Final

Report also considers the current case management crisis and asks the Board to oversee a process that ensures appropriate support and management of social workers. The Commission's recommendations include:

- **Focus on Prevention:** To reduce the overall incidence of child abuse and neglect, the Board should direct the Department of Public Health and First 5 LA to jointly develop a comprehensive prevention plan.
- **Provide Parity of Funding for Kinship Caregivers:** Given that at least 51% of children removed from their parents are placed with relatives, kinship caretakers should be recognized as invaluable to the child protection process. They should receive parity of funding to that of non-relative foster placements and equal access to services.
- **Initiate a Comprehensive Case Review Process:** The Board should direct the CEO to initiate the case review process proven successful in Florida and other safety-focused industries to help identify risk and protective factors that can improve outcomes for children.
- **Expand Interdisciplinary Training:** Keeping children safe is an interdepartmental problem that demands interdepartmental training. Entities must work together more effectively and better understand one another's roles.
- **Improve Data Sharing**: The County needs to develop a single, coordinated system to facilitate and encourage the sharing of information, at a minimum, among DCFS, DPSS, DMH, DPH, Probation, LACOE, other school districts, and the Dependency Court, prioritizing the best interests of the child.
- **Increase Transparency:** The Commission heard repeatedly that it was virtually impossible for the public, including advocacy groups, to understand the planning process or how diverse funding streams were allocated for services to children and families. Sustainable accountability and reform require greater disclosure, clarity, and inclusion.
- **Improve Educational Stability:** Coordinated efforts among DCFS, probation, school systems, Dependency Courts and community partners should be enhanced to increase educational continuity, school stability, and academic success.
- **Expand Mental Health Services:** The County must ensure access to high quality and consistent mental health services for all those involved in the child welfare system, including the prioritization of non-pharmacological interventions for children.
- **Expand Performance-based Contracting:** The DCFS contracting process should focus on outcomes rather than compliance with contractual provisions.
- **Include the Voices of Stakeholders in Decision-making**: Stakeholders should be at the center of the decision-making process, rather than on the outside looking in.

The Board should adopt the recommendations set forth in the Commission's Final Report.

IV. CONCLUSION

The Commission believes that implementation of its proposals will dramatically improve the safety, health, well-being, and life success of the children of Los Angeles County.

Consistent with our critique of the County's siloed approach, our recommendations should not be reviewed quickly or in isolation. Their transformative power is directly related to understanding them as an interdependent set of reforms. They reflect sound business principles that are foundational to any successful organization.

The systemic obstacles we have described have taken a toll on all the participants of the system. It is the Commission's hope that with a clearly defined County vision for the safety and well-being of its children, structural reform, meaningful partnerships with the community, and shared-responsibility across departments, all involved with our child protection system will see that change is possible and have a renewed sense of purpose.

The children for whom this report was written deserve to grow up free from abuse and neglect and to realize their full potential. It is our responsibility to make this possible, *now*.

FINAL REPORT

On our watch, many of Los Angeles County's most vulnerable children are unseen, unheard, and unsafe. Sparked by tragic child fatalities, community outrage, and a series of unsuccessful attempts at reforming the County's child protection system, the Board of Supervisors established the Blue Ribbon Commission on Child Protection (Commission) on June 25, 2013. In its motion, the Board charged the Commission to:

- Review previously delayed or failed efforts to implement reforms and provide recommendations for a feasible plan of action to expeditiously implement needed reforms;

- Review the systemic, structural and organizational barriers to effective performance. These may include such factors as the current structure, scope of the Department of Children and Family Services (DCFS) and relevant County departments, including the departments of Health Services, Mental Health, Public Health, and Sheriff, the District Attorney, the Dependency Court and commissions, various memoranda of understanding, and the relationship of DCFS to the Board; and

- Review, at its discretion, the child protection failures, including DCFS policies and cases.

In October 2013, the Board instructed the Commission to provide an Interim Report by December 31, 2013, and to issue its Final Report by April 18, 2014.

The Commission is grateful to the Board for allowing us the opportunity to review the current child protection system and recommend substantial reforms.[1] Given the gravity of the task and the multitude of recommendations received by the Board over the years, the Commission determined that the Board deserves more than a cursory review leading to prejudged conclusions. Therefore, the Commission pursued a fresh perspective and process that is comprehensive, inclusive, and transparent, including:

- **Fifteen public hearings** at which State agencies, Los Angeles County departments, universities, school districts, nonprofit organizations, and many others provided testimony.

- **Interviews with more than 300 stakeholders** across all program areas related to child safety.

- **Focus groups with the people most impacted by the policies and practices of the child welfare system**, including children and youth 13-17 years old; transition age youth

18-25 years old; LGBT youth; formal and informal kinship caregivers; birth parents; and foster and adoptive parents.

- **Review of relevant previous recommendations made to DCFS and other County agencies.** In consultation with Walter R. McDonald & Associates, Inc. (WRMA), a database was created to organize and categorize prior recommendations related to child protection and safety dating back to 2008. Over 700 recommendations contained in 29 documents were reviewed and analyzed.

- **One-on-one, in-depth interviews with leaders in the child welfare field, conducted by Commissioners and Commission staff.** These included extensive interviews with members of law enforcement, DCFS, DHS, DMH, and the District Attorney's Office, as well as many community and academic leaders.

- **Review of best practices and relevant reports on child abuse.** The Commission reviewed promising practices and reports considered and/or utilized in other jurisdictions to assess what can be learned and applied in Los Angeles County. It also drew important information from state and local databases and academic studies and articles.

- **Constituent correspondence received by the Commission.** Constituent letters and email inquiries were reviewed and incorporated, where appropriate.

- **Review of individual child fatality case files pursuant to an Order granted by the Presiding Judge of the Juvenile Court.** The Commission reviewed the 25 most recent child fatality cases in Los Angeles County, determined by DCFS to have been caused by child abuse or neglect, as well as the cases of Gabriel F., Dae'von B., and Erica J.

See Appendix 1 for a full description of the Commission's information-gathering process. Testimony and presentation materials can be found at www.blueribboncommissionla.com.

We especially wish to acknowledge the many examples of resilience, heroism, and commitment that we witnessed during our eight-month review process. In spite of the challenges in our current system, we heard from youth who managed to overcome years of abuse and trauma to rebuild their lives. Parents told us about turning their lives around and subsequently being able to raise their children after tragic incidents of abuse or neglect. We heard from relative caregivers who opened their homes to a family member and parented them as if they were their own. We heard from social workers and other first responders who spent countless hours making extraordinary efforts to ensure children were safe. We heard from County leaders trying to improve the system through expanded and effective services.

We also heard from many others who have devoted their lives to improving the system and providing justice and healing for children and youth who have experienced unspeakable trauma. The Commission for Children and Families has been at the forefront -- suggesting systemic change, a focus on prevention, and ensuring community input. We repeatedly heard from the media, in print, online, and on air. They inform the public and serve as vigilant watchdogs -- keeping the need for reform in the spotlight.

At the same time, the Commission heard testimony that infants spend hours on the desks of social workers due to a shortage of foster homes and an inefficient placement process. Many children do not receive the minimally required monthly visits by caseworkers or have trusting relationships with them. Social workers, meanwhile, are overwhelmed by caseloads significantly above state and federal recommended levels.[2] They often do not receive sufficient support, supervision, or training. Similarly, the judicial system operates under the burden of too many cases to give adequate time for deliberation and all stakeholders a meaningful voice.

The Commission also heard that children in foster care often are placed with many different families, leading to multiple school transfers and academic failure. It is not unusual for foster children to fall three years behind their peers at school. The more than 50% of foster youth who are placed with relatives have greater safety and stability. Yet, due to an inequitable funding system, their caregivers generally receive far less financial support and gain access to fewer services than non-relative caregivers. Financial support currently is determined by the child's type of placement rather than by his or her needs.

Community groups and clients of the system, who should be at the center of planning, feel devalued and unheard. Many youth reported to the Commission that they could not even reach or trust their social worker – the person that should be their most important safety resource. In eight months of focus groups, interviews, and hearing hundreds of hours of testimony, the Commission rarely heard a defense of the current child safety system.

Instead, we heard:

- **No single entity in the County oversees all aspects of child protection.** No single entity is held accountable for what happens to at risk children before, during, and after they are in the County's care. Previous attempts at reform have not been sufficient because no single entity is charged with integrating resources across departments for the benefit of children.

- **County departments that should work together often operate in silos.** County entities that should collaborate in planning, funding programs, and providing services to effectively serve children fail to adequately communicate and coordinate efforts. These entities include the Departments of Public Health, Mental Health, Health Services, Children and Family Services, Public Social Services, Housing, the Sheriff's Department, and Probation, as well as the Los Angeles County Office of Education, First 5 LA, and various commissions.

- **There is no County-wide strategic plan.** Strategic planning does not reflect the contributions of various departments and does not leverage all County and community resources.

- **No County-wide mission or measurable outcomes guides policies and practices.** The Board has not adopted a County-wide mission related to the protection and well-being of

children that identifies clear, measurable outcomes and child-centered, family focused goals.

- **Child protection is not viewed as a County-wide responsibility.** The failure to protect children cannot be attributed to one agency or department. DCFS is not and cannot be solely responsible for all aspects of child protection. Improved child safety is a system-wide issue. The one person most often identified as accountable – the Director of the Department of Children and Family Services – has almost no control over the planning for or utilization of many of the resources necessary to keep children safe.

- **Persistent turnover in the leadership of the Department of Children and Family Services (DCFS) has devastated morale and created endless directives.** Eighteen Directors in 26 years has taken a disastrous toll, leaving a trail of uncompleted agendas, conflicting goals, overburdened job requirements, and interrupted relationships.

- **The County's child welfare system reflects a culture driven by crises, not data.** Actions taken are too often driven by a crisis, rather than by County-wide data and case reviews. Data should identify where the needs are, and plans should be developed to meet and fund the high priority needs. Many described the child protection system as a "pendulum," swinging back and forth with each major incident instead of driven by core values.

- **Fear of liability preempts sound decision-making by the County and DCFS.** Protection of the County from perceived liability at times trumps protecting children. Likewise, social worker decision-making is influenced by fear of termination and liability.

- **Communication among people and agencies is often limited by perceived confidentiality restrictions, to the detriment of child safety and well-being.** Crucial access to information between appropriate entities, within County government and throughout the community, often is needlessly blocked in the name of confidentiality. Problems within the system remain hidden and often uncorrected because of secrecy around decision-making and other recurring failures.

- **The system's ability to optimally respond to the needs of the child is compromised by the lack of information and data sharing.** The difficulty of accessing and receiving information between agencies is often cited as one of the single most important impediments to needed reforms. While part of the problem is related to confidentiality concerns, there also are other major issues associated with incompatible data systems.

- **There is little budget or planning transparency.** It is virtually impossible for internal stakeholders or the public to understand how diverse funding streams are allocated for services to children and their families. An opaque budgeting process makes it virtually impossible for disparate departments, agencies and community groups to effectively evaluate or improve the child safety system.

- **Children, youth, and families report disrespectful treatment and exclusion from the decision-making process.** Focus groups and testimony included widespread reports of rude or dismissive treatment, a feeling of re-victimization, failures to communicate, and rigid points of view.

- **Gaps in the service continuum compromise safety.** There is no conceptualization of or clarity around the need for a full continuum of strategies and services, beginning with prevention and extending through aftercare, in order to ensure that children and youth are safe. Services should be needs-based and determined by data.

- **Diminished engagement and a severe reduction in partnerships with community and faith based organizations has further compromised the service continuum.** This includes foster care and group home providers. The community perceives it no longer has a voice in DCFS's strategic planning process. Instead, decisions are made and implemented without the community's knowledge or input.

- **Service provider contracts are not awarded based on program outcomes.** Efforts to improve safety are severely hampered by a DCFS contracting process that emphasizes compliance with contractual provisions instead of a focus on performance. Performance-based contracts are the exception, rather than the rule, at DCFS. This leads to loss of programs with successful outcomes because of emphasis on other criteria. Services to children and families are disrupted, delayed and not assessed for quality.

- **The County lacks a rapid response mechanism.** Children are dying, being severely injured, failing/dropping out of school, becoming homeless, and heading to prison, yet there often appears to be no sense of urgency to solve problems. There is no rapid response team across departments to identify and continually address obstacles to providing good service. There is not one entity that tackles impediments to improved services by identifying what those impediments are and then advocating for reforms, including needed policy changes or legislative fixes.

- **Unrealistic expectations unfairly burden social workers and clients.** The existing system often creates unrealistic expectations for social workers who struggle with dramatically higher than average caseloads, overly cumbersome policies, and inefficient technology and procedures for placement of children. Social workers are responsible for placements and service referrals, but these resources are often limited or non-existent.

- **The response of law enforcement is inconsistent and sometimes inadequate.** Law enforcement's role in protecting children is sometimes hampered by failures in cross-reporting; variable standards for investigation among the 46 law enforcement entities; significant delays in retrieving reports of child abuse from DCFS; and the need for mandatory and continuing training for all levels of law enforcement personnel.

- **There is inadequate access to medical and mental health services.** The six Hub clinics that are part of the County-wide Medical Hub Program were conceived to provide comprehensive services to address the medical and mental health needs of children at

risk, including expert forensic, medical, and mental health evaluations for every child detained or at risk for detention; appropriate evaluations for children at the time their families receive family preservation or reunification services; and services for children in foster care and the probation system. However, the Hubs do not have sufficient resources to implement these services. All of the Hubs need immediate support to align them with their original goals.

- **Striking resource inequities exist across sectors of the County**. Some DCFS Regional Offices are significantly understaffed relative to the number of children under their supervision in that service area. In addition, communities with the highest need are served by the fewest nonprofit services.

- **Personnel from all relevant departments are not adequately trained and cross-trained.** This is important to better understand each department's role and to develop a sense of shared responsibilities and an understanding of respective responsibilities. Universities' expertise is not sufficiently utilized to provide cross-training. Additional and ongoing training and cross-training is needed for first responders and mandated reporters, such as teachers.

- **Promising practices and evidence-based policies are under-utilized.** While some advances have been made through partnership initiatives, such as the Violence Intervention Program at LAC+USC Medical Center and Stuart House at UCLA Medical Center, these collaborative models are the exception rather than the rule. The County seldom reviews or implements promising practices from other jurisdictions, such as integrated service delivery and co-location of staff.

- **Social workers are often blamed for system-wide failures.** It is easy to point the finger at a single social worker to explain the tragic death of a child. This dissuades deeper examination of the underlying causes of a child fatality, creates constant fear of termination, and ignores broader system failures. Further, social workers perform better in a child welfare system culture that holds them responsible for good practice and supports them through tragedy, rather than scapegoating them for system-wide failures.

- **The lack of available placements has created a crisis.** Children have been kept in the Welcome Centers for 23 ½ hours before being signed out, only to return after spending the day at a Regional Office, thereby evading policy violation. Some have remained in the Welcome Center for as long as 8 days, being shuffled back and forth to a Regional Office during the day.

- **Often the least experienced social workers are assigned to assess complicated emergency situations without sufficient resources and support.** Front-end investigation failures have consistently been found to be a major systemic weakness, causing many child fatalities and serious injuries.

- **Inadequate attention has been given to prevention services.** Currently, services typically do not begin until a child or family has contact with the child welfare system.

The focus has been on DCFS decision-making and the back-end to the neglect of other important points of contact. This is far too late to keep children safe. Further, resources are overly burdened by an excessive number of referrals and investigations. Los Angeles County conducted 170,000 investigations of alleged child abuse and neglect which is far more than any other similarly sized jurisdiction.

- **There is no effective strategy of identifying and providing services for children most at risk.** Testimony and research have found that children under age five are at the greatest risk of death from abuse or neglect and that fatality rates are highest among infants under age one. There is no County-wide safety net of services to prevent their abuse in the first instance.

- **There is widespread dissatisfaction with the lack of sufficient support for kinship caregivers.** Although the system relies on kinship care, in the majority of cases, only a handful of social workers are designated to support these caregivers in meeting children's needs. Some of the issues include their dire need for more financial support disrespectful treatment by social workers; lack of information about resources and services; lack of continuity of DCFS social workers; and lack of access to court orders and participation in dependency cases.

- **There are major disruptions to education.** Foster youth experience multiple school transfers and foster home placements, losing about three years of critical learning due to school instability. Their graduation rate from high school is almost half the rate of the general population. Routinely, they must deal with lost, misplaced, or inaccessible school records, hindering timely school enrollment and appropriate school placement and services.

- **The community expressed pointed concerns about recent DCFS policies and practices.** Focus groups and interviews with community groups reported significant concerns about: the increase in out-of-home placements, which has risen by approximately 1,700 children or 10% overall, the first increase in 12 years; increases in disproportionality, particularly for Latino children; and significant decreases in family services.

- **Clients – children, parents, caretakers, and relatives – are not treated as collaborators, but often as adversaries.** While many social workers are caring and engaged, the overall culture of workers in LA County was not seen as respectful or collaborative by those who rely on them: youth in foster care, transition aged youth, parents, foster parents, relative care givers, or biological parents. Constituents repeatedly stated the need for a County centralized grievance system or body responsible for handling and addressing complaints regarding DCFS and other County workers, located outside of DCFS. Constituents also noted with great frequency the need for help navigating the complex and fragmented child welfare system. See Appendix 2 for a report summarizing the results and recommendations from a series of focus groups and interviews conducted with client populations involved with the child protection and foster care systems.

- **The Dependency Court is burdened with excessively high caseloads.** The lack of available prevention and early intervention services has contributed to the highest caseload since 2007. Early intervention services should be available and utilized by DCFS when families can safely be diverted from the Court process. These high caseloads often result in inadequate time for proper deliberation.

- **The Dependency Court is not consistently provided with complete and timely information on which to base its decisions.** The quality of the Court's decisions is directly related to the accuracy and depth of the information it receives. DCFS does not consistently provide the Court with all relevant information from County Departments and other stakeholders. Given the seriousness of the decisions it makes, the Court must be provided this information in a complete and timely manner to make the most informed decisions for the child.

- **The system fails to see itself through the eyes of a child**. Despite the intention of the County to protect children, sensitivity to their needs and circumstances is not prioritized. Children and families involved in the system constantly deal with multiple social workers and other service providers, which forces them to tell and retell their stories on many different occasions and prevents a consistent and comprehensive understanding of their needs. The process is dehumanizing and frustrating for clients. In addition, children often experience multiple placements, separation from siblings, inconsistent visits with parents, continuous school changes and loss of personal belongings. The system re-victimizes children when decision-makers do not consider the trauma of these multiple losses and intrusions on the child.

In addition, DCFS and Court data revealed:

- As of March 2014, 36,766 children were receiving some form of child welfare service, an increase of 1,460 from the previous year. The number of children in out-of-home placement was 20,676, an increase of 1,257 from the previous year.

- Of the 2,154 child fatalities reported to DCFS in the last 6 years (2008 - 2013), 46% (nearly 1,000) were children who had some prior contact history with DCFS.

- The reported number of child fatalities has steadily declined from 400 in 2008 to 328 in 2013. However, child deaths with prior DCFS history increased from 146 to 159 between 2012 and 2013.[3]

- There were 179,951 referrals to the DCFS hotline in 2013. Referrals ranged from 170,808 to 185,685 between 2008 and 2012 with no discernable pattern. For example, there was a noticeable drop in 2009 (from 170,808 referrals in 2008 to 162,377 in 2009). There was a dramatic spike in 2012 (185,685 referrals). Referrals in 2013 remain on the relatively higher end.

- Fifty-nine percent of referrals from 2008 through 2013 had prior DCFS referrals.

- On average, the percent of referrals that are substantiated is approximately 18%.

- Substantiations are also highest among children aged 0 (11% of all substantiations). Forty-one percent of all substantiations are of children aged 0-5.

- General Neglect represents 43% of all allegation types. Emotional abuse (17%) and at-risk, sibling abused (12%) are the second and third most common types of allegation.

- The low rate of substantiation and the frequency of recurrent referrals informed the Commission's recommendations on prevention.

- There was an increase in recurrence of allegations after exits from the child welfare system (substantiated cases) from 14.5% in 2008 to 17% in 2011.

- In 2013, a total of 14,344 new petitions were filed in the Dependency Court, approximately 900 more than 2012 and significantly above the 2009 total of 10,725. This volume of petitions requires approximately 25-30 cases to be on each courtroom's calendar per day. Such an excessive caseload compromises the Dependency Court's ability to devote adequate time to each case. The end of 2013 the Court witnessed the highest number of children under its jurisdiction since 2007.

- ICAN will soon release its annual report with new data, but the 2012 report indicates there were a total of 24 homicides of children at the hands of their caregivers in 2011, a decrease of 11.5 percent from 2010.

These data point to some positive trends that should be further examined. However, they also indicate trends that, if not addressed, continue to compromise child safety. A more careful review of child welfare data is needed. Such a review should inform allocation of child welfare resources and effort. In the Commission's final analysis, there is an urgent need to address the most concerning trends.

In the course of our work, the Commission reviewed the DCFS files of 28 recent child fatality cases caused by child abuse and neglect (as determined by County Counsel and DCFS), including the Gabriel F., Dae'von B. and Erica J. cases referenced in the Board's Motion. The results of this review support the testimony and research provided to this Commission:

- 13 of the 28 children were under the age of 2;
- 21 of the 28 children were under the age of 5; and
- 22 of the 28 families had prior reports to the DCFS hotline.

While DCFS has reported implementation of the vast majority of prior recommendations from recent years, serious problems persist in the County's child welfare system. However, DCFS is not solely responsible for all aspects of child protection. In fact, it has almost no control over the planning for or utilization of many of the resources necessary to keep children safe. The problem is not that County leaders and workers do not care. The system is simply not structured

to translate that caring into effective action. Accountability, child-centered programming, and grounded decision-making can only take place if a single oversight and coordinating body assumes leadership of the reform process.

IMMEDIATE ACTION BY THE BOARD OF SUPERVISORS

The Commission believes that there is a State of Emergency that demands a fundamental transformation of the current child protection system. Nothing short of a comprehensive approach to reform will lead to the seamless and comprehensive child welfare system that the County has needed for decades.

Below, we provide a set of recommendations that are feasible, practical, and will improve child safety.

I. ARTICULATE A COUNTY-WIDE MISSION TO PRIORITIZE AND IMPROVE CHILD SAFETY

The Board has not articulated a County-wide mission and goals for children, youth, and their families. The current siloed approach that characterizes County operations has created gaps in services. The Board should lead a paradigm shift by articulating a clear vision for the children of Los Angeles County, engaging County and community leaders, and listening to clients of the system in this process. Such a County-wide mission to improve child safety is essential to:

- Ensure unanimity of purpose within the County;
- Provide the basis for interdepartmental strategic planning;
- Effectively allocate County resources across departments;
- Translate related objectives into a cross-system, unified structure that delineates tasks across agencies within the County; and
- Establish appropriate cost, time, and performance parameters for ongoing monitoring, assessment, and course adjustments.

The mission statement is not just a guiding principle for department heads and top level management to set forth on paper. It is a critical message that must infiltrate the entire network of people working in the child protection system. Our focus groups have revealed great frustration, fear, mistrust, and lack of faith in our system. From front line social workers to foster parents, from mental health providers to relative caregivers, from medical doctors to children and youth, there is a malaise shrouding many of the people working to make a difference for children and families. As the sea-change takes place at the top, so must that message of shared responsibility, open communication and respect permeate throughout the system.

The child welfare mission should reflect the values that have guided this Commission's recommendations: a system that is child-centered and family-focused; requires inter-agency collaboration and partnerships with diverse stakeholders; is committed to safety, permanency, and well-being of children; recognizes the value of prevention and a continuum of care; makes data-informed decisions and is accountable for results; respects the importance of the community

and the safety net it provides; honors transparency and real community partnerships; and is committed to excellence.[4]

Recommendation: The Board should mandate that child safety is a top priority. It should articulate a child-centered, family-focused, County-wide Mission and call for:

- **All relevant County entities to work together and with the community;**
- **Joint strategic planning and blended funding streams;**
- **Data-driven programs and evaluations;**
- **A comprehensive service delivery system, including prevention programs that stop child maltreatment before it starts; and**
- **An annual overview of the state of the field of child welfare, presented to the Board by external consultants and experts.**

This mandate must pave the way for a new system that values transparency in its finances, practices, and outcomes. It must be keenly attuned to the voices of those whom it is designed to serve, including participation from youth and culturally diverse communities. Department directors, as well as the CEO, should be selected, evaluated, and measured on their ability to achieve goals emanating from this mission.

II. ESTABLISH AN ENTITY TO OVERSEE ONE UNIFIED CHILD PROTECTION SYSTEM

Six years ago, the Commission for Children and Families urged the Board to tackle the system's dysfunction by posing the fundamental question that this Blue Ribbon Commission seeks to answer today: "who is responsible and held accountable for the development of a plan which includes defining roles, implementation, oversight, evaluation, analysis and holding all partners accountable for performance?"[5] Now is the time for the Board to set in motion the structural and other changes that answer that question once and for all.

The Board clearly has been confronted with the problem of a failed system and fragmented decision-making for years. DCFS is not and cannot be viewed as solely responsible for all aspects of child protection. The County's safety net for children should involve many departments, including the Departments of Public Health, Mental Health, Health Services, Children and Family Services, Public Social Services, and Probation, as well as First 5 LA and various commissions. Currently these entities have difficulty communicating effectively, working together on integrated planning to improve child outcomes, and combining funding resources. Thus, the County, and by default its children, have lost their ability to benefit from the sum of its parts.

The February 4, 2014, meeting at which the Board considered the Commission's Interim Report served to illustrate several of these County shortcomings. There was:

- **A lack of communication and coordination among departments.** It was apparent that the Directors of DCFS and Public Health had not discussed the feasibility of implementing the Commission's recommendation that public health nurses accompany DCFS workers in appropriate cases, despite the fact that both departments would be affected. There was clearly no entity responsible for facilitating this inter-agency coordination.

- **No mechanism to respond quickly to legislative and regulatory barriers.** Although legal impediments were raised by department heads regarding restrictions on the scope of work of these nurses, there does not appear to be an ongoing process or entity in place, akin to a strike team, to deal quickly with circumstances that may require a legislative fix. There is no inter-agency team that regularly identifies needed changes and preemptively highlights reforms for Board action. This delays reform by months or prevents it from taking place at all.

- **No sense of urgency.** Nearly four months have elapsed since the Commission issued its interim recommendation on which everyone seemed to agree to: performing medical screening exams on detained children under age one. The Commission highlighted the urgency of implementing this recommendation given the high vulnerability of this population. The Deputy Director of Strategic Planning for the Department of Health Services indicated that DHS could implement it *within existing resources*. And still, four months later, this recommendation has not been acted upon.

Across the country and internationally, many jurisdictions have reevaluated their child protection systems amidst similar allegations of dysfunction. While their approaches differ, all have concluded that the child protection functions of multiple departments must be integrated and coordinated to provide the best results. For example, in Allegheny County, Pennsylvania, all child protection and human service entities and resources have been combined under one agency. Driven by this integrated approach, data, clear goals, and strong community partnerships that include nonprofits, universities, businesses, and foundations, the county reduced its foster care placements by 57%.

One entity must be vested with the authority to ensure that relevant County departments develop a joint strategic plan, clear goals, an agreed-upon delivery system, joint funding streams, and measureable results. Such an entity is the precursor and the linchpin to sustaining other significant, needed reforms, including the crucial recommendations set forth in this report.

Systemic defects cannot be solved by piecemeal efforts and isolated recommendations. The Commission unanimously agrees that there must be one entity responsible for the safety and well-being of the child as a whole. This entity should have no other competing responsibility. It must have the authority to recommend to the Board movement of resources and staff across relevant County departments.

Recommendation: The Board should establish an entity, which could be called the Los Angeles County Office of Child Protection (OCP), with County-wide authority to coordinate, plan, and implement one unified child protection system. The director of the entity would report directly to the Board and be held accountable for achieving agreed upon outcomes. The director must be vested with over-all responsibility for child protection in the County and shall:

- **Oversee a Joint Strategic Planning Process. In close collaboration with all relevant department heads and community stakeholders, the director must lead a process to create a comprehensive, child-centered strategic plan that is data driven, informed by best practices, connects all child welfare services in the County, and articulates measurable goals and time frames.**

- **Have clear oversight and authority over financial and staffing resources from all relevant departments, as delegated by the Board.**

- **With regard to all resources related to child welfare, institute an annual County-wide budget review process which examines all proposed, present, and past resource allocations and aligns them with the goals of the County-wide strategic plan. The director also should coordinate relevant funding streams from various departments, explore strategic uses of Title IV-E and other flexible funding sources, and allocate funding based on a shared County child welfare mission, strategic plan, annual goals, and measurable outcomes.**

- **Review existing County commissions and all recommendations related to the protection of children. Oversee implementation of appropriate proposals, as well as the streamlining of existing commissions.**

- **Establish and evaluate measurable outcomes as part of the annual planning and budget allocation process. Such a system would facilitate constant improvement, generalizing successful pilot programs to the whole system, and discontinuing unsatisfactory practices.**

- **Oversee County-wide prevention efforts.**

The Director also should reach out to the philanthropic community and build strategic partnerships to help improve the child protection system. When this outreach strategy to philanthropy was used by the Allegheny County Department of Human Services in Pennsylvania, 15 foundations came together to partner with the County to create a more integrated system that they designed together. The power of public-private partnerships has been under-utilized by the County to date and should be an important strategy for improving services.[6]

Given the history and complexity of the County, the Director of this office must have a passion for protecting children and be well-versed in the field of child welfare. The Director also must have experience in leading change within complex and entrenched organizations and be comfortable in challenging existing policies. The Director should be adept in problem solving,

skilled at communicating, able to lead and guide in a collaborative setting, and unafraid of risk. While the Commission realizes that this combination of leadership traits may be difficult to find in one person, the gravity of the issue and the challenge of effecting change of this magnitude require it.

The majority of the Commissioners voted to establish a Los Angeles County Office of Child Protection, which would report directly to the Board, as the best vehicle to bring about sustained comprehensive reform. The Commission recognizes that the Board may want to explore other approaches to accomplish this objective.[7]

See Appendix 3 for a fuller discussion of the rationale for creating an Office of Child Protection.

III. DEFINE MEASURES OF SUCCESS AND OVERSEE THE REFORM PROCESS

The Board should regularly assess the County's performance on meeting articulated child safety goals. Improved safety for children will not be achieved in the absence of strong governance, a transparent process, and clear outcomes. In order to lead effectively, the Board should have a regular process of review, based on reliable data. Assessments should include the following outcomes:

- Overall incidence of abuse and neglect per capita by a geographic area to be determined (e.g., supervisorial district, zip code, SPA). This is a measure of both prevention efforts and services.

- Overall incidence of severe abuse and neglect per capita by a geographic area to be determined. Child fatalities are a low incidence subset of this group. Severe abuse and neglect is a better barometer of overall child safety in Los Angeles County.

- Recurrence of maltreatment within 6 months. This is a measure of the percentage of children experiencing newly reported abuse or neglect within 6 months of a previous incident. This is a measure of decision-making and service effectiveness.

- Number of child fatalities due to abuse or neglect. This is a critical measure of overall safety and system performance, although it occurs too infrequently to be the only measure.

Other meaningful outcomes the County should assess relate to well-being. These might include access to services; engagement with juvenile justice; and graduation rates from high school and college.

Recommendations:

1. **The Board should adopt clear outcome measures which should include those set forth above.**

2. **The Los Angeles County Office of Child Protection (referred to in Section II) should regularly assess the County's progress and report its findings directly to the Board. These findings should be reviewed regularly at Board meetings.**

The Inter-Agency Council on Child Abuse and Neglect (ICAN)

In 1977, the Board established ICAN "as the official County agent to coordinate development of services for the prevention, identification and treatment of child abuse and neglect." ICAN's Child Death Review Team conducts a "multi-agency review of intentional and preventable child deaths for better case management and for system improvement placed within DCFS. ICAN can be a resource in providing important data, as well as trend and case review analysis, to the Board and County leadership. It should be considered as an independent resource for data provision to the Board in overseeing the reform process.

Recommendation: ICAN should be removed from within DCFS and exist as an independent entity.

IV. ADOPT THE COMMISSION'S INTERIM REPORT RECOMMENDATIONS

On December 30, 2013, the Commission provided the Board with an Interim Report, comprised of ten recommendations capable of immediate implementation. See Appendix 4 for the Commission's Interim Report. Since then, another 5,000 referrals of child abuse and neglect have been investigated without the benefit of systemic reform. Each day we wait for reform, 40 more infants are reported as possible victims of abuse or neglect. On February 4, 2014, the Board unanimously adopted a motion to refer the Commission's Interim Report recommendations to the Chief Executive Office (CEO) for a feasibility and fiscal analysis, and to report back to the Board within 60 days or in conjunction with this Final Report. The Commission has requested, but not received, an update on the progress of the analysis.

Listed below are the relevant Interim Report recommendations, as well as several new, inextricably related ones that build upon or clarify those set forth in the Interim Report.

Law Enforcement and the District Attorney's Office

The District Attorney's (DA's) Office, the Los Angeles County Sheriff's Department (LASD), and the other 45 law enforcement agencies in the County play a critical role in protecting children from abuse and neglect. State law requires that these entities cross-report the case to each other and to the DA's Office. Investigations by both child welfare and law enforcement agencies are required because their responsibilities and areas of expertise differ.

To assist communication across agencies, in 2009, DCFS, the DA's Office, and LASD launched the Electronic Suspected Child Abuse Reporting System (E-SCARS), a real time, web-based information sharing system that allows rapid and secure electronic transmission and receipt of mandated cross-reports. E-SCARS significantly improved DCFS and law enforcement communication by eliminating delays and potential errors caused by cross-reporting via mail or fax; ensuring that the proper agencies receive the report; and providing a detailed history of

alleged past incidents of abuse entered into the system by DCFS. This information often is not on a rap sheet and is a significant tool in investigating possible current criminal activity.[8]

Unfortunately, insufficient resources have been allocated for updating and maintaining E-SCARS, as well as for needed oversight by the DA's Office. The DA's Office could help address the following system failures set forth by the Commission in its Interim Report:

- Failure by some law enforcement entities to cross-report Suspected Child Abuse Reports (SCARs) to DCFS and the DA's Office and document their actions;
- Differing standards among law enforcement agencies for investigating reports of alleged abuse;[9]
- Inadequate methods of retrieving cross-reported SCARs by law enforcement so that some are not seen for days;[10] and
- Lack of sufficient mandatory and continuing training for all levels of law enforcement personnel on handling child safety cases.

In addition, the DA's Office could assist with proposing or supporting needed legislative reforms. For example, concerns have been raised about the Child Abuse Central Index (CACI), which is overseen by the California Department of Justice. Due to a 2012 amendment to State law, law enforcement agencies are prohibited from submitting reports of suspected child abuse occurring outside of the home. Thus, if a child is abused by an individual outside of the home and there is no DCFS involvement, law enforcement cannot enter the suspected abuser's name into CACI.

Insufficient training of law enforcement personnel on child safety was another challenge identified by witnesses:

- There is inadequate training on child abuse and E-SCARS. This training should be required at least annually for all Patrol Unit officers. The training of individual officers should be documented and tracked.[11] Since the LASD Special Victims Bureau (SVB) has the responsibility to train Academy and Patrol personnel, as well as investigate all criminal allegations of child abuse, the Sheriff's Department should maintain or enhance this Bureau with the necessary staffing to fulfill these responsibilities at the highest level. A minimum of one hour of training on child abuse and E-SCARS should be provided by the SVB to all enrollees in Patrol School, Field Training Officer School, Field Operations School for Sergeants, and Field Operations School for Lieutenants.[12] In addition, other law enforcement agencies should provide similar training programs.

- Critical information learned from cases investigated by the Children's Special Investigations Unit (CSIU)[13] or ICAN's Child Death Review Team[14] is not integrated quickly into trainings and practice so that mistakes are addressed and not repeated.

- Law enforcement personnel are not sufficiently trained to inquire about and physically check for the presence of children in the home when responding to domestic violence cases. If present, children should be interviewed separately from the adults for signs of physical or emotional injury, as recommended by ICAN. A report should be made to

DCFS regarding suspected risk to the children's safety and well-being.[15] ICAN's 2012 Child Death Review Team Report points out that "domestic violence is often present in families where fatal child abuse has occurred. In one of the 2011 child homicides by a parent, law enforcement had been to the home several times for domestic violence calls, the last one two weeks prior to the child's death." The report also notes that the connection between domestic violence and child abuse "continues to be evident in the 2011 homicides in which nine of the families had a history of domestic violence."[16] The DA's Office, ICAN, and the Los Angeles County Domestic Violence Council can play an important role in designing appropriate training.

- Many in law enforcement are unfamiliar with the possible indicators of sex trafficking of youth, especially those residing in foster care Group Homes. In light of reports of increased sex trafficking, especially in SPA 6, additional training is needed for law enforcement and social workers to be able to recognize those indicators.

Recommendations:

1. All Sheriff's deputies and local law enforcement agencies within the County of Los Angeles must cross-report every child abuse allegation to DCFS, as required by State law. In addition, it should be documented that a cross-report was made, for example, in a police report or law enforcement log. LASD reports that it has implemented this recommendation. The DA's Office should work with other law enforcement agencies to do the same and review the success of LASD's implementation efforts.

2. E-SCARS should be utilized fully by all relevant agencies and receive the necessary support to be well-maintained and enhanced.

3. The DA's Office should increase its oversight of the law enforcement response and sharing of information, including cross-reporting between DCFS and law enforcement agencies, to ensure that each agency carries out its mandated investigative response. Since our Interim Report, the DA's Office has proposed establishing an E-SCARS Unit to facilitate needed improvements by all law enforcement entities in the County in responding to child abuse and neglect reports. The Commission supports funding this Unit. See Appendix 5 for the Los Angeles County District Attorney's description of its proposed E-SCARS Unit.

4. Training of all levels of law enforcement must be enhanced to include: sufficient initial and recurrent training on child abuse and E-SCARS; "lessons learned" from important case reviews; cross-training with social work, mental health, and other relevant personnel; and additional training on responding to domestic violence calls and identifying instances of abuse that may be occurring in group homes, including sex trafficking exploitation which victimizes a high percentage of foster care youth.

5. The County should develop an early warning system within E-SCARS to alert DCFS and law enforcement of high-risk allegations of abuse as early as possible. A convergence of

high-risk factors would alert supervisors of high-risk situations and allow them to take appropriate action.[17]

If the County adopts the recommendations set forth above, important innovations, such as E-SCARS and an E-SCARS Unit within the DA's Office, could be models for replication around the State and country.

Health Services

Medical or developmental issues may be symptoms of child abuse or neglect. When those signs are missed or not addressed, the risk of repeat abuse, serious injury, or even death increases. A medical examination can help to determine whether or not there signs of abuse. See Appendix 6 for a study regarding the important role that specially trained child abuse physicians can play in providing appropriate evaluations.

In 2006, DHS, DCFS, and DMH partnered to develop the County-wide Medical Hub Program to build a system of medical and mental health care that, in partnership with DCFS, would guarantee that every child detained or at risk for detention had access to expert medical/mental health evaluations to promote appropriate interventions and child safety. Ultimately, the Hubs were designed to provide the foundation for building a medical/mental health home for children in foster care.

Currently, six Hub clinics provide a limited number of medical and related services under the auspices of the DHS. All of them have out-stationed DCFS workers as partners and provide expert forensic evaluations, as well as initial medical evaluations of children detained by DCFS and placed in out-of-home care. However, only one, the Hub at LAC+USC Medical Center, provides comprehensive services supported by a number of departments and 24-hour, 7-day a week inter-agency services.

The Hubs need immediate support to align them with the original goals of providing the following services in each Supervisorial District:

- Expert forensic, medical, and mental health evaluations for every child detained or at risk for detention, as well as for children at the time their families receive family preservation or reunification services;
- Expert forensic, medical, and mental health assessments;
- Re-evaluation for children who were in foster care or who had unsuccessful foster placements, remained in group homes for longer than six months, or returned home either through family preservation programs or reunification;
- A mandated "medical home" and ongoing services for children who are in foster care; and
- A "re-entry" service for children who were followed by both the probation and the child welfare systems.

Assessments should be conducted to identify each Hub's strengths and weaknesses and devise strategies to meet the needs of their geographic area. For example, Martin Luther King Medical

Center (MLK) is the best site for immediate assessment and expansion of services to meet the pressing needs of high-risk families in Service Planning Area 6. This assessment and expansion should also address the needs of sexually exploited foster youth found at high rates close to MLK clinics.

In addition to expanding Hub involvement, the skills and expertise of Public Health Nurses should be used to improve and enhance DCFS's investigative processes. Their participation would immediately improve decision-making. This approach has been utilized successfully in several communities around the country.

The Department of Public Health's evidence-based home visiting program has reduced the risk of subsequent abuse and neglect. These critical services should be expanded to reach all children under age one who are seen at a Medical Hub. DCFS must remain in continuous contact with these medical personnel to facilitate appropriate detention and placement decisions, as well as service referrals.

Recommendations:

1. Assessments should be conducted to identify each Hub's strengths and weaknesses. Strategies should be devised to meet the needs in each geographic area. The Violence Intervention Program at LAC+USC Medical Center is the most comprehensive Hub that is closest to meeting articulated goals and has the greatest ability to conduct a neutral assessment.

2. All children entering placement and children under age one whose cases are investigated by DCFS should be screened at a Medical Hub. Children placed in out-of-home care or served by DCFS in their homes should have ongoing health care provided by physicians at the Medical Hubs.

3. A Public Health Nurse should be paired with a DCFS social worker in child abuse or neglect investigations of all children from birth to at least age one.

4. DPH's evidence-based home visit service should be made available to all children under age one who are seen at a Medical Hub.

5. DPH must be held directly responsible for substance abuse treatment for high-risk teen mothers.

Expansion of this Hub system will help save children's lives and enable DCFS to better evaluate and appropriately place children.

Children Age Five and Under

Improved child safety depends on identifying children who are at the greatest risk for a serious or fatal injury and providing them and their families with high-quality, accessible, and appropriate services. We know that in Los Angeles County:

- Children under five years old are at the greatest risk of death as a result of abuse or neglect.
- Fatality rates are highest among infants under age one.
- A report to a child protection hotline is the single best predictor of a child's injury-related death before age five, including both deaths due to maltreatment and deaths due to unintentional injury. This is true regardless of whether DCFS legally substantiates the abuse or neglect.
- More than three quarters of the roughly 8,000 infants who are reported to DCFS each year remain with their families of origin after the first hotline report. Fifty percent are subsequently reported for a second report of maltreatment before age five.[18]

National child fatality trends mirror Los Angeles County statistics. National Child Abuse and Neglect Data System (NCANDS) data for 2011 demonstrated that children younger than one year accounted for 42.4% of fatalities and children younger than four years accounted for four-fifths (81.6%) of fatalities.

Given that fatality risks are most pronounced for children reported to child protective services during their first year of life, this is a period during which service interventions are most impactful.

> Recommendation: The County can measurably and immediately improve child safety by requiring all departments to target resources and high quality services, including prevention services, toward children under the age of five.

As previously proposed to the Board, the Commission makes the following recommendation:

Recommendation: The Board should adopt the recommendations of the Commission's Interim Report, along with the above related recommendations. Implementation of these recommendations will improve front-end decision-making, which numerous previous reports have documented as having contributed to fatalities in the past.

V. RESOLVE THE CURRENT CASE MANAGEMENT CRISIS

Integration of roles and responsibilities across many sectors is necessary to improve and ensure child safety. However, DCFS has a unique responsibility for protecting children. DCFS social workers are the most visible and accountable front line practitioners, as they are primarily responsible for case management services designed to protect children and ensure their best interests. We heard consistent testimony from social workers that they struggle with unreasonable workloads that include high caseloads, difficulties locating appropriate placements for children, and burdensome policies and paperwork. Social workers themselves thoughtfully

recognized the systemic problems within DCFS that compromise safety to children. In a 2009 White Paper presented to the Board and DCFS leadership, one social worker described, "The list of policies and task[sic] that we have to deal with is literally impossible to do even in a 12 hour day."[19]

The quality and quantity of time that DCFS social workers spend with children and families directly affect the accuracy and effectiveness of decision-making. Most concerning was evidence that significant numbers of children receive limited face time and/or are not seen at all by social workers on a monthly basis, severely compromising child safety. Youth's frustration with their limited contact with social workers was powerfully described by one of our youth focus group members: "Why can't my CSW and her supervisor just answer the phone? I keep trying and they are not there." Regular communication with their clients is essential to creating the necessary bond for improved safety and well-being.

Social workers most often enter the profession to help children and families, and want to be true to that vocation. To allow them to appropriately focus on their client's needs, social workers recommended that "DCFS should remove responsibilities that are redundant, excessively time consuming, unlikely to improve child safety, and not required by state or Federal law." Creating a system with better support, training and resources should relieve social workers from ineffective use of their time and improve their client contact and decision-making capabilities.

The Commission recognized that DCFS has its strategic plan that has been endorsed by the Board. Full implementation of that plan should address many of the issues mentioned by social workers as well issues related to prevalent and tragic front end decision-making failures. Furthermore, the Board vigorously debated the creation of the Commission based on concerns that the Commission would threaten the progress of DCFS's strategic plan implementation. Finally, the Commission has observed that DCFS presents regular strategic plan updates to the Board. Therefore, while the Commission has had the opportunity to review the strategic plan, we have neither assessed the quality of the plan nor made recommendations regarding its content. We view this as an issue between the Board and DCFS and beyond the charge of the Commission.

We fully endorse DCFS's development of a strategic plan and the Board's active oversight of it. However, testimony received by the Commission raised concerns about the plan's efficacy. In addition, DCFS's plan does not reflect a County-wide, inter-agency child welfare effort. Therefore, the Commission urges the Board and DCFS to revisit the plan's impact. We recommend that the Board intensify its direct oversight of the strategic plan with the enhancements set forth below.

It is important to note that if the Board establishes an Office of Child Protection, DCFS's strategic planning process would become part of the entity's integrated planning and evaluation process.

Recommendations:

1. **The Board should continue its active oversight of DCFS's strategic plan by adding a requirement for regular reporting of specific safety related outcomes, including recurrence of maltreatment within six months of a previous incident, maltreatment**

rates in out-of-home placement, and reentry into care within six months of a permanent placement.

2. **The Board should require regular reporting on the frequency of missed monthly social worker visits, the wait times for children in offices or at the Command Post needing placement, the length of time for kin caregivers to be approved, and the number of foster homes recruited.**

3. **The Board should establish specific benchmarks for improvement in the measures identified in one and two above, as warranted. This should be done in collaboration with the CEO and DCFS.**

VI. RECOMMENDATIONS TO ADDRESS THE OUT-OF-HOME PLACEMENT CRISIS

Challenges associated with out-of-home placement contribute significantly to the current child protection emergency. Testimony presented was inconclusive in identifying whether the out-of-home placement system is over utilized or under resourced. However, it is clear that today there is a crisis that puts children in danger.

Kinship Care

Kinship care is the most frequent placement option for children in Los Angeles County. Between 51 and 53% of the County's approximately 30,000 foster children are placed with relatives.[20] For the vast majority of children, kinship care placements are less traumatic, lead to better outcomes, play a pivotal role in ensuring children's safety, increase placement stability, better assure success in school, and maintain family and community connections.[21] Despite all of these benefits, and despite the fact that State law mandates it as the preferred placement option, children in kinship care and their caregivers are among the most underserved in the County's child welfare system.

Kinship care families receive significantly lower payments and fewer resources than unrelated foster parents.[22] These disparities are based solely on where the child resides. The child's needs remain the same.[23] DCFS should utilize more fully its ability to waive federal eligibility rules, such as the 1996 income/resources rules that prevent relative caregivers from receiving federal foster care benefits. The County has no restrictions on who can receive IV-E waiver dollars.[24]

The Commission's kinship caregiver focus groups and interviews substantiated critical issues also identified in the literature.[25] Caregivers repeatedly and passionately described:

- Their dire need for more concrete financial support to meet the needs of the child/ren placed in their care;
- The need for child welfare agencies to provide birth parents with better access and support for substance abuse and mental health services;
- Mistrust and disrespect by child welfare agency workers;
- Treatment as "babysitters" rather than partners by the child welfare system;

- Inadequate information about the child welfare system in general and confusion about their legal options;
- Lack of information about resources to meet the needs of children in their care;
- Lack of continuity and the disruption associated with the high turnover of DCFS social workers;
- Their own need for basic supports such as subsidized child care, respite for themselves, and informal supports such as peer support groups for emotional support; and
- Uncertainty about the process of the child's dependency case, limited or no access to court orders, and inaccurate information about their participation in court proceedings.

Kinship care is a frequently utilized placement option for children in imminent harm of abuse or neglect and a necessary resource for a system struggling to recruit enough foster homes. These caregivers should be most valued and assisted. There are a number of remedies to ameliorate the unnecessary challenges faced by relative caregivers.[26] Every opportunity possible should be made to locate, approve, and place children with appropriate kin and ensure they are not waiting in an office or at the Command Post. In addition, supports are necessary to assure that kin caregivers can provide children with safe, stable homes but according to kin these supports are limited in availability and are of limited effectiveness. Furthermore, testimony revealed that kin caregivers wait unnecessarily extensive periods of time to be approved by the county and that financial supports that should be available to all children who have been abused or neglected and in need of out of home placement are not available to children placed with kin. The Commission finds that these issues contribute to the out-of-home placement crisis by extending stays for children in unstable, potentially dangerous settings and preventing their safety and well-being needs from being met. The Commission recommends the following as first steps to address the needs of children placed with relatives.

Recommendations:

1. **A child's funding should be determined by the needs of the child, not whether placement is with a relative or a foster family. The CEO and DCFS should examine the County's ability to waive federal eligibility rules and its accompanying funding flexibility to strengthen support for children in out of home care.**

2. **The County and DCFS should utilize its Title IV-E waiver dollars to ensure parity of funding for children placed with kin to that of children placed in foster family settings**

3. **A child's services should be based on the needs of the child, not whether placement is with a relative or a foster family. The CEO and DCFS should ensure that relative caregivers are more fully supported to address a range of possible needs.**

4. **The County, through the auditor controller and the CEO, should review the current mix of county licensing and supports for foster homes and approval and supports for kin, to assess the inconsistent performance and resource allocation, and to determine whether a more uniform streamlined system would be more effective. The Commission believes consideration of contracting out this process is warranted.**

Recruitment of Non-relative Foster Homes

Commission witnesses and focus groups revealed unacceptable practices resulting from the shortage of safe and appropriate foster homes. Many children were placed in homes far away from their schools, friends, and communities. DCFS social workers often struggled to find suitable homes, forcing them to keep children, sometimes only days old, at Command Posts or Child Welcome Centers or place them in temporary foster homes. The shortage of homes adds to the number of placements, contributes to the dislocation and instability felt by these children, separates siblings, and increases the workload of social workers.

Both Foster Family Agencies (FFAs)[27] and DCFS recruit, certify or license, and train foster parents to care for non-relative children. The most recent available statistics indicate that there are 3,000 FFA-certified homes with 7,013 beds and 584 DCFS recruited homes licensed by the State with 1,753 beds. This dual system of recruitment and licensing should be reviewed to determine whether one entity would be preferable. At the very least, both DCFS and the FFAs would benefit from a coordinated strategy, campaign and standards for recruitment with strong support from community groups and philanthropy.

In addition, a centralized, real time database that indicates available homes and provides profiles of the foster parents, including their skills, level of experience, and accessibility to a child's school of origin would increase the likelihood of successful placements and significantly support social workers, who often spend hours on the phone searching for appropriate foster homes.

Recommendations:

1. **The Board should call for an independent analysis of non-relative foster family recruitment efforts in the County to determine how the system can be more efficient and effective. The analysis should use sound data to address a range of questions, including whether there are safe and appropriate homes in each SPA to meet the needs of foster youth.**

2. **DCFS should develop a computerized, real-time system to identify available and appropriate placements based on the specific needs of the child.**

3. **DCFS should involve foster youth in the rating and assessment of foster homes.**

VII. RECOMMENDATIONS NECESSARY TO SUPPORT THE COUNTY-WIDE SAFETY SYSTEM

To create a County-wide, interdepartmental service delivery system, the Commission presents recommendations for a system with the full array of services needed for prevention and treatment of child abuse and neglect. Our recommendations cover a Comprehensive Prevention System, Cross-training, Technology and Data Sharing, Transparency and Relationships with Providers and the Community, Education, and Mental Health.

Improve Safety: Eckerd Rapid Safety Feedback Best Practice

Using data wisely can save lives and improve service delivery and outcomes for children. Faced with unprecedented increases in child fatality, places like Hillsborough County, FL searched for ways to better identify the causes of and find immediate solutions to child fatalities. Eckerd, in Partnership with Mindshare (Software Company), developed a preventative analytics software system that served as an overlay to Florida's Statewide Automated Child Welfare Information System. It gave them the ability to mine thousands cases that had produced poor safety outcomes for children. It identified 15 data points, such as the age of the child, placement, and family situation, that were determined to be highly correlated with the poor safety outcomes. Equipped with specific case information identifying children at greatest risk, Eckerd strategically allocated resources to address risk factors immediately. Remarkably, Hillsborough County achieved a 100% reduction in child fatalities. This process is effective no matter the size of the jurisdiction. It and can be applied to Los Angeles County to identify children at greatest risk.

Recommendation: The Board should direct the CEO to immediately implement the process used by Eckerd in Hillsborough County, Florida and in other industries to achieve remarkable safety results. The following components of this process are minimally required:

- **Conduct a review of all child fatalities due to abuse and neglect within the past three years of children served in a Department of Health Services (DHS) medical hub, DCFS, Probation, the Department of Public Social Services (DPSS), by a DPH public health nurse or home visiting program or by a First 5 LA home visiting program.**

- **Conduct a thorough review of all open cases in the above departments.**

- **Review research findings from Emily Putnam Hornstein, Ph.D. and others on the risk factors for Los Angeles County children at risk for later child fatality due to abuse and neglect, as well as data from the Inter-Agency Council on Child Abuse and Neglect (ICAN).**

- **Using both case review and research findings, identify specific characteristics that distinguish children who have positive outcomes versus those who are subsequently severely injured or killed. Specifically identify key risk factors that are present in cases resulting in child fatalities.**

- **Equipped with specific case information and research findings that identify children at greatest risk, proactively engage staff in the above child-serving departments to address risk factors immediately, thereby mitigating the likelihood of a child fatality.**

- **Utilize a technological solution such as E-SCARS that crosses departments, to ensure that information is shared and staff alerted when potentially fatal risk factors are present.**

- **Continually measure progress against the measures of success identified in Section III.**

- **Modify access to and delivery of key services including: health; mental health; domestic violence; substance abuse treatment; housing for adults; home visiting; and prevention supports for children, youth, and families. These services will need to be prioritized for those at highest risk for later fatalities.**

A Comprehensive Prevention System

Testimony before the Commission revealed that the County gives limited attention to prevention of abuse or neglect as a key strategy to improve child safety. Instead, the County has used a costly and often ineffective strategy of waiting for children to be harmed and then providing emergency resources. Underscoring the lack of value placed on prevention services, DCFS itself recently criticized its own Family Maintenance program. A sound safety system prevents children from suffering abuse and neglect.

In addition to reducing the pain and suffering of innocent victims, prevention reduces the significant costs of child welfare intervention and decreases poor societal outcomes for children in the foster care system. Further, it would relieve Dependency Court caseloads, allowing more time for deliberation. Unless there is an effective prevention strategy that reduces the incidents of abuse and neglect, particularly targeting efforts towards those who are at greatest risk of fatality, we are not on a sound course. At worse, we are waiting for children to die. At best, we are overwhelming the system with untenable rates of referrals and investigations.

Services typically do not begin until a child or family has contact with the child welfare system, usually with DCFS. The focus has been on DCFS decision-making and the back-end to the neglect of other important points of contact. This is far too late to keep children safe. Further, resources are overly burdened by an excessive number of referrals and investigations. Los Angeles County conducted 170,000 investigations of alleged child abuse and neglect which is far more than any other similarly sized jurisdiction. The most cost-effective way to reduce the rippling costs of child welfare is to prevent abuse in the first place.

Los Angeles County does not have a comprehensive plan for child abuse prevention. DCFS does not adequately allocate its expenditures towards prevention, nor is it targeting those at greatest risk. This creates a huge hole in the safety net for children. Without closing that hole, efforts to dramatically improve the child safety will not succeed.

The Title IV-E waiver gives the County the ability to implement substantive prevention services such as Prevention Intervention Demonstration Project (PIDP), Triple P, and others to address the high incidence of referrals and investigations. Other jurisdictions have been effective in reducing the reported incidence of abuse and neglect by identifying those children at highest risk and targeting evidence-based services, like home visits, to those children and their families.

Recommendation: The Board should direct DPH and First 5 LA to jointly develop a comprehensive prevention plan to reduce the overall incidence of child abuse and neglect.

Training and Workforce Development

Multiple agencies have responsibility for child safety in Los Angeles County. Yet, each has its own language, own definition of "safety," and often its own information systems. None has a comprehensive plan to work in collaboration with other agencies in the service of child safety. Keeping children safe is an interdepartmental problem that demands interdepartmental training. Entities must work together more effectively and better understand one another's roles. The University Consortium for Children and Families (UCCF) can provide important input into DCFS's and other County training models. It also would be beneficial to have at least an annual meeting between the UCCF and relevant departments to share information and develop appropriate training models.

Recommendations:

1. **Departments and agencies closely involved in the identification, prevention, protection, and treatment of at-risk children should be mandated to participate in cross-training with DCFS employees. At a minimum, this interdisciplinary approach should include law enforcement, the Department of Mental Health (DMH), DHS, DPH, the Dependency Court, and the Probation Department. Entities that could help create appropriate cross-training models include the UCCF, the District Attorney's Office, and ICAN.**

2. **DCFS, DMH, and DHS should train personnel, both in-house and in contract agencies, on how to most effectively work with the age 0 to 5 population, their families, and caretakers.**

3. **The UCCF should submit an annual report on outcomes that are aligned with the County's vision.**

4. **DCFS should create an innovative, open and adaptive training process for social workers and their supervisors that consists of a continuous learning environment, with training and research, akin to a teaching hospital. It should also conduct a job audit of social workers to determine what can be done differently or by others to address social worker workload.**

Technology and Data Sharing

Children and youth served by the child welfare system often face multiple challenges including trauma, poverty, school failure, violence, substance abuse, mental health disorders, truancy, and unstable home lives. Multiple systems frequently respond based on partial pictures, and are unable to get to root causes or whole child/whole family solutions. Without shared information, comprehensive case plans, effective treatment, and optimal court decision-making are not possible.

Data informs needs, services, and strategies at both the individual and systems levels. Data sharing can be used to: (1) address the needs of the individual child or family; (2) evaluate child welfare goal attainment or program outcomes; (3) identify trends; (4) inform public policy and resource allocation; (5) discern modifiable factors to improve child outcomes; and (6) reveal common child/parental/community risk and protective factors to reduce rates of abuse and fatalities.

It is imperative to establish a mechanism for timely access to information across jurisdictional boundaries to meet children's and families' needs. In this regard, the question posed to County Counsel should not be "whether" data sharing across departments and with the Dependency Court can be done, but, rather, "how" it can be done while addressing HIPPA, FERPA, State Welfare and Institutions Code section 827 protections, and other relevant laws. A balance must be found between a child's privacy protections and his or her safety and well-being.

A number of data sharing resources have been identified to assist counties like Los Angeles in this regard. At a minimum, the County should consider the following:

- Sharing individual information to enhance understanding of a child's needs or circumstances in order to improve planning and decision-making;
- Sharing aggregate data on case populations to develop and improve policies, practices, and programs and to coordinate responses among multiple agencies; and
- Sharing aggregate data for performance measurement and program evaluation.

Data sharing efforts must take several issues into consideration, including confidentiality, policies and procedures, the establishment of common data elements, the integration of different information systems, and more. These are not insurmountable. Other sectors of the country, have successfully brokered MOUs, entered into effective data sharing agreements, changed practices and advocated for legal changes to the benefit of children and families while ensuring confidentiality and legal protections. For example, South Carolina has the longest standing and most comprehensive data sharing system in the country. Pittsburgh/Allegheny County has made significant progress in establishing integrated data for practical use and has successfully modeled school absenteeism trajectories and multisystem intervention points through data sharing. The Administration for Children and Families is encouraging child welfare systems across the country to participate in data sharing efforts.

Recommendations:

1. **The County needs to develop a clear, multi-system data linkage and sharing plan that would operate as a single, coordinated system. At a minimum, County agencies that should be included in a data sharing process are: DCFS; DPSS; DMH; DPH; Probation; LACOE; and school districts within the County. The County should also partner with universities to share data that identify needs and priorities.**

2. **The CEO and the Juvenile Court should co-lead the creation of a County-wide confidentiality policy regarding a child's records and court proceedings to allow sharing of information across relevant departments, agencies, persons, and the**

Court to serve the needs of the child and increase the transparency of the system. The priority must be the best interest of the child, rather than liability avoidance.

Transparency and the Relationship with Providers and the Community

Relationships between agencies, public and private, are often crucial to child safety and to the success of any service delivery system. The community and providers must be recognized and valued as partners. The County can re-establish its relationship with providers and the broader community by increasing transparency of its decision-making, budgetary, and evaluation processes, and by adopting performance-based contracting.

Transparency. Transparency implies openness, communication, and accountability. The Commission heard repeatedly that these qualities are no longer reflective of child welfare practice in the County. It is virtually impossible for the public and other County departments to understand how diverse funding streams are allocated for services to children and their families. Decisions related to priorities, strategies, and direction within DCFS are not inclusive of the perspectives of families, community providers, and interested stakeholders. In the past, Title IV-E waiver resources were used to convene the community annually to contribute to County planning – a process that was highly regarded by the community.

> Connecting separate agencies that serve children and families at the intersection of child welfare, substance abuse services and dependency courts involves connecting the multiple funding streams that flow into child welfare, substance abuse and other health and human service agencies serving families. The more comprehensively a continuum of care is defined in children and family services, the wider an array of funding streams are needed. The more committed an agency is to "family-centered services," the more mastery is needed of all the different funding streams that can support families. No single agency has adequate funding sources by itself to achieve comprehensive outcomes; interagency funding streams are therefore critical to converting hopes for new linkages into reality.[28]

LA County does not operate from the above paradigm. The County's approach to child welfare funding and the goals of child welfare are misaligned. The practice of considering only incremental additions to existing budgets, as is now often the case, fosters inefficiency, stifles inter-program innovation, and makes continuous improvement impossible. Child welfare finance reform aimed at better aligning the goals of child welfare and the funding incentives/disincentives inherent in various funding streams is needed. There are children in foster care right now that could safely have remained at home if there were a broader array of prevention and intervention services. Similarly, there are children in care right now who could move more quickly to reunification if more effective services were available. There also are children who are not going to be reunified that need to be moved more quickly toward permanency, but the resources must be in place to support this. DCFS alone cannot fund all of these within its current budget structure and practice.

Consistent with national trends in best practice, the County needs to increase prevention, intervention, reunification, and permanency services. This begs the questions, what is the current ratio of resource allocation in these categories and how could it be different? The answer to the first question requires greater budget transparency and tracking of child welfare resource allocations within and beyond DCFS. The answer to the second question rests in the County's ability and commitment to (1) strategically use the Title IV-E waiver and (2) creatively use existing, relevant funding streams (e.g., found in TANF, Medicaid, Mental Health and Education) to address child and family needs. This requires a fundamental shift in thinking and practice. Rather than the money following current federal or state practice requirements, the County must shift to a model where the money follows the needs of children and families.

The proposed budget process reforms are cost-effective and can lead to better outcomes such as those found in Florida's use of the IV-E child welfare waiver. Through flexible funding strategies that involve planning across county departments, the Commission believes that Los Angeles can among other things:

- Improve child outcomes, including permanency, safety, and well-being;
- Enhance family supports with an expansion of the array of child welfare services based on the unique needs of communities
- Increase the number of children who can safely remain in their home or return home;
- Increase children's placement in kinship care;
- Improve caregiver training, engagement and retention;
- Address critical problems associated with disproportionality in the County; and
- Decrease the proportion of expenditures on out-of-home care and increase the proportion of expenditures on prevention and in-home services.

Child welfare finance reform along with greater budget transparency, a careful inventory of resources already at play, and shared planning/decision-making provide the conditions necessary to improve the County's child welfare system.

The Commission can neither predict the cost savings that will result nor accurately project its ultimate financial impact on the County. Such projections should be possible. However, after many inquiries, the Commission (1) found no central place that could provide the total number of resources now devoted to the welfare of children within the County; (2) could not ascertain the percentage of the total County budget allocated to child welfare; and (3) could not decipher the dollars spent (including allocation of IV-E waiver dollars) within the current method of budget reporting used by DCFS. Led by a new Director of Child Protection, a collaborative, more transparent process is possible.[29]

Performance-based Contracting. A number of front line professionals characterized the existing DCFS contract process as "abusive."[30] They report they are required to submit proposals for different programs simultaneously, with inadequate prior briefing or preparation. Providers feel the contracting process requires them to "start from scratch," with little recognition given to prior performance.

Organizations with the longest history of funding by DCFS tend to view contracting as the agency's weakest area of operation. In an initial effort to address this weakness, the Board of Supervisors charged DCFS with revamping its contract monitoring processes. The DCFS Director outlined a reorganized plan designed to streamline internal contracts management. Annual reviews for compliance and fiscal management in funded programs are proposed, an advance over previous practice. However, no explicit attention is given to review of program outcomes, reinforcing the impression that technical compliance takes precedence over programmatic outcomes.

As an alternative, performance-based contracting focuses on results associated with quality and outcomes. Objectives and time frames are specified and agency payment is tied to program outcomes. Performance measurement is a strong indicator of service quality, and if properly done, can help ensure that contractors are accountable. For example, New York's Department of Youth and Community Development's "Out of School Time" program was required to document enrollment and attendance or face a 10% reduction in reimbursement. In addition, performance-based contracting works best when service provider agencies are involved in the development of the performance indicators.

Recommendations:

1. **Greater disclosure, clarity, and inclusion should be a routine component of community engagement from planning to review of outcomes and allocation of resources. A first step is the re-establishment of community advisory councils that are attached directly to each DCFS Regional Office. These advisory councils would be co-chaired by the community and its respective Regional Office. In the past, SPA 6 effectively used this model in all three of its offices.**

2. **Performance-based contracting on agreed-upon outcome measures by DCFS, other appropriate departments and the contracting agencies for children and families should be adopted, rewarding contracting agencies that achieve better results for the children they serve.**

3. **Capacity-building experts, including universities, should work with community-based organizations to enhance skills in grant application and administration, evidence-based practice, program design, and evaluation.**

Education

In Los Angeles County, thousands of students in foster care face an inordinate number of challenges. They often lack stability in school placement, continuity of educational services, and a consistent relationship with a caring adult who can participate in their school lives and advocate for their educational needs. Eighty percent of foster youth are held back in school at least once by the time they reach third grade. On average they lose over three years of critical learning due to changes in foster homes. They change schools an average of six times during their school career, losing four to six months of learning with each transfer. The lack of accountability and coordination across systems exacerbates children's unstable educational progress. Moreover, the pressures of school disruptions; traumatic experiences associated with

abuse, neglect, separation, and impermanence; and learning difficulties, create a recipe for disastrous outcomes in school, and in later adult life.

Youth in foster care deserve and need better educational coordination, stability, continuity, advocacy and opportunity. The County must ensure that the resources exist to help foster youth reach their educational potential.

The Commission has identified three overarching recommendations that are critical to improving the education system's ability to effectively support foster youth.

Recommendations:

1. **The County should establish mechanisms for cross-system education-related coordination, collaboration, and communication. We endorse the structure of the Education Coordinating Council (ECC), and they should continue to establish additional mechanisms for cross-site collaboration. The new child welfare structure proposed by the Commission must jointly engage DCFS, probation, school systems, the courts, and community partners to create cross-systems goals and strategies to improve educational continuity, stability and academic success for foster youth.**

2. **The County should increase access to early intervention services for foster children and children at high risk of abuse and neglect. All children under the supervision of DCFS between 0-5 should be prioritized for access to Early Childhood Education learning programs, including Head Start, Early Head Start, and Home Visitation. These programs should be funded and well marketed. Once placed in a program, children should be permitted to remain enrolled until they start kindergarten.**

3. **The County should ensure that school stability and child safety are improved through County-wide expansion of the pilot program that has been proven effective in the Gloria Molina Foster Youth Education Program.**

Mental Health

Mental health issues underlie many of the causes of abuse and neglect. Parents often need treatment for mental health disorders and major life stressors, including those related to substance abuse, depression, domestic violence, and poverty. Access and coordination of these services for parents are critical to keeping children safe and enabling their safe return to their parents. These services must be known to social workers and accessible to parents, both geographically and financially.

Children and youth may enter the system with mental health symptoms related to previous diagnoses, their abuse and/or neglect, removal from their homes, placement, school or social challenges, to name a few. In July of 2002, a lawsuit was brought against the State and the County alleging that children in foster care, or at imminent risk of foster care placement, were not receiving necessary and legally mandated mental health services. The Katie A. settlement

agreement created an Advisory Panel to oversee implementation of mental health services agreed upon by the parties. DCFS created a Child Welfare Mental Health Services Division (formerly known as the Katie A. Division) to ensure compliance with the lawsuit.

Even with the benefit of Katie A., a number of issues remain with respect to addressing the mental health needs of children and families. One of the unmet needs identified by a number of witnesses was mental health treatment programs designed for infants and young children. A number of witnesses emphasized that mental health treatment programs designed for these children help alleviate distress and suffering, reduce symptoms related to trauma, build protective factors, and support healthy outcomes.[31]

> While infants are disproportionately impacted by child maltreatment, their development and mental health needs are often unrecognized and unmet by child welfare agencies. Children between zero and three continue to be the age group most likely to be maltreated. Considering more than half of newly detained children are under the age of 5, it is crucial for the mental health system to continue to build capacity and strengthen competencies in the field of infant and early childhood mental health specifically for those infants and young children in the child welfare system.[32]

The importance of early intervention is also highlighted in the annual California Children's Report Card issued by Children Now:

> Significant adversity experienced in early childhood, such as stress associated with persistent poverty or chronic neglect, can severely impact brain development and lead to decreased mental and physical well-being throughout a child's lifetime. Even very young children can suffer from serious mental health disorders: over 10% of children, ages 2-5, are diagnosed with a mental health disorder.[33]

Further, the Commission for Children and Families recommended that the Department of Mental Health be directed to "jointly train personnel, both in-house and in contract agencies, on how to most effectively work with the age 0 to 5 population, their families and caretakers because this population is not now receiving the mental health attention required by victims of early childhood trauma."[34]

We also heard of the importance of mental health services and the protection of children through adolescence. Children in foster care have higher levels of mental health challenges. When their mental health needs are not addressed, it contributes to further negative outcomes, such as school failure, unemployment, poverty, early parenthood, homelessness, suicide, and incarceration.[35] Mental health services are needed across the developmental spectrum for children in care, inclusive of adolescence and transition age youth.

Despite significant efforts by the Dependency Court to obtain detailed information on the necessity for psychotropic medications, testimony also revealed consistent concern about the reported over-utilization of these drugs. As was noted by Wendy B. Smith, Ph.D., LCSW, Associate Dean, USC School of Social Work:

> Psychotropic drugs have not been as extensively tested with children as with adults, they can have complicated side effects, and the long-term effects on brain development are unknown. Treating behavioral symptoms only sometimes causes us to overlook underlying or other reasons for these behaviors. Children in our care deserve treatment plans that are as thoughtful and cautious in the use of these medications as those provided to other children. We are taking chances with children's futures. The use of psychoactive drugs should always be justified by psychiatric assessment, clinical evidence, treatment plans, and frequent, careful monitoring.[36]

The timing of the following recommendations may be fortuitous. The Affordable Care Act makes mental health services "an essential benefit" in children's health coverage. This means that children's access to mental health coverage and care should be substantially increased this year.[37]

Recommendations:

1. **The Board should issue a clear mandate that non-pharmacological interventions are best practice with children wherever feasible. The Board should work with the Juvenile Court to fully implement and measure compliance with this mandate.**

2. **As part of performance-based contracting, mental health treatments for teens and transitioning youth must incorporate trauma-focused assessment and treatments, developmental status, ethnicity, sexual identity, and vulnerability to self-harming behaviors.**

3. **Children age five and under in the child welfare system must have access to age-appropriate mental health services.**

VIII. ESTABLISH AN OVERSIGHT TEAM TO ENSURE IMPLEMENTATION OF RECOMMENDATIONS

Thoughtful oversight has been a critical missing component in previous attempts at child safety reform and the implementation of prior recommendations. See Appendix 7 for an overview of over 700 prior recommendations from various commissions, panels, and grand juries. Therefore, to ensure the implementation of our recommendations, the Board should immediately appoint an Oversight Team. The importance of this team cannot be overstated. Without a strong strategy and sense of urgency for implementing reform, the Commission fears that reform proposals, like others in the past, may fall through the cracks. This Oversight Team would help the Board oversee the full realization of its directives.

The Oversight Team should be co-chaired by an individual external to the County system, with business or organizational management experience, as well as a County leader, identified by the Board, with child-welfare experience. The team should include the Presiding Judge of the Juvenile Court, up to five members of this Blue Ribbon Commission, up to five members of the County Commission for Children and Families, and up to five other individuals chosen by the Board, including a youth representative who has had first-hand experience with the County's child welfare system. The majority of the Commissioner voted to establish this Oversight Team as the best configured entity to oversee full implementation of these recommendations. The Board could utilize the expertise of ICAN and the Domestic Violence Council. The Oversight Team's membership should reflect diverse departmental perspectives to mitigate a continuation of silos.[38]

During the transition period, it is important to have a focused approach to implementing recommendations that support child safety. Formal advice to the Board regarding recommendations for child safety should be limited to this one proposed Oversight Team, until a new, over-arching child welfare entity is established along the lines proposed in this report. This team could engage the expertise of diverse stakeholders including families and emancipated youth, philanthropic, business, academic, and union leaders. The Oversight Team will need access to expertise in organizational change, project management, and federal and state funding streams dedicated to child protection. Philanthropy can provide needed expertise and support as well. Successful transformation requires that the CEO and relevant County department directors work directly with the Oversight Team. In addition to overseeing implementation of the Commission's recommendations, the Oversight Team would assess the continued efficacy of multiple commissions advising the Board about children's issues and make a recommendation to the Board within six months. The Oversight Team should be available for up to two years after the creation of the new child welfare structure.

Recommendation: The Board should immediately establish an Oversight Team. Initially, the Oversight Team would be charged with the following three tasks:

1. **Oversee implementation of the Commission's recommendations upon adoption by the Board.**

2. **In collaboration with the Board, identify the services currently provided by the Departments of Health Services, Children and Family Services, Public Health, Probation, Mental Health, Public Social Services, First 5 LA, the Los Angeles County Office of Education (LACOE), the Domestic Violence Council, and the Housing Authority of the County of Los Angeles deemed as crucial to ensuring child safety. The accompanying budget and staff resources also should be identified.**

3. **The Oversight Team must develop a dashboard to provide monthly reports to the Board.**

IX. CONCLUSION

Often, despite the best of intentions, the County's child welfare system has veered off course -- resulting in tremendous frustration at best, and tragic casualties at worst. This is not a time for piecemeal change or tinkering on the edges. It is a time for thoughtful, County-wide strategic paradigm shift in the way we view and treat at-risk children. The Board has begun the first step by creating this Commission. We hope that the Board will adopt the Commission's complete set of reforms and partner with the best thinkers and leaders in the community and around the country to create meaningful and lasting change.

In the final analysis, the safety and welfare of children are not just a government responsibility. The Commission believes that the children discussed in this report are *all of our children.* Their welfare is in all of our hands. And we, as a society, are only as strong as our most vulnerable child.

The community plays an essential role in supporting children, as a former foster youth told us:

> I went through the foster care system for seven years of my life. It was an auntie who came into my life that made the difference. She lived in poverty and thought that I was coming for two weeks. It was 20 years, bless her heart. And thanks to the counselors and teachers that connected with me at schools, I thrived. I can't say thanks to a social worker because I was considered a case number, not a name. We need to give foster youth those opportunities of service, support, and care by the entire community, because *it does take a village to make a difference in a child's life,* so they can also be a superintendent, a judge, a police officer, a doctor, and a social worker.

This former foster youth, Richard Martinez, went on to become the Superintendent of the Pomona Unified School District and a member of our Blue Ribbon Commission on Child Protection.

All of us who want to engage in improving the system should remember what the Commission heard many times over – a fact summarized succinctly by Dr. Wendy Smith in her testimony:

> If we were to identify, among all potential protective factors, the single most important one, *I would say it is a real, meaningful connection to a caring and consistent adult – that is a lifeline***.** Positive experiences can "rewire" the brain, altering neuronal responses, just as traumatic experiences do.

In this spirit, the Commission wishes to recognize and especially thank all who act as lifelines for children in many different ways – as volunteers for community nonprofits, as relentless advocates for needed reforms, as members of county commissions, as mentors, as former foster youth, as loving relative caregivers and foster parents, as committed social workers. You set an example for others to emulate and help shine light on a system in need of reform.

APPENDICES

APPENDIX 1

Blue Ribbon Commission on Child Protection Information-Gathering Process

Given the gravity of the task and the multitude of recommendations for reform the Board has received over the years, the Commission determined that the Board deserves more than a cursory review leading to prejudged conclusions. Therefore, the Commission pursued a fresh perspective and process that is comprehensive, inclusive, and transparent, including:

- **Fifteen public hearings** at which the following State agencies, Los Angeles County departments, universities, school districts, and nonprofit organizations provided testimony: California Health and Human Services Agency; Chief Executive Office (CEO); Department of Children and Family Services (DCFS); Sheriff's Department (LASD); Department of Mental Health (DMH); District Attorney's Office (DA); Department of Health Services (DHS); Department of Public Health (DPH), including Substance Abuse Prevention & Control (SAPC); Probation Department; Department of Coroner; Department of Public Social Services (DPSS); Inter-Agency Council on Child Abuse and Neglect (ICAN); Los Angeles County Office of Education (LACOE); Los Angeles Unified School District (LAUSD); First 5 LA; the Commission for Children and Families; Dependency Court; Domestic Violence Council; LAC+USC Medical Center; University of Southern California School of Social Work; University Consortium for Children and Families; Children's Law Center of California; Alliance for Children's Rights; Public Counsel; Child Welfare Initiative; Stuart House; relative caregiver organizations, including Kinship in Action, Community Coalition, Grandparents as Parents, and ROCK; representatives from the Countywide Community Child Welfare Coalition, including SHIELDS for Families, Project IMPACT, Bienvenidos, Para Los Niños, and Children's Institute, Inc.; members of the Association of Community Human Service Agencies, including Optimist Youth Homes & Family Services, David and Margaret Youth and Family Services, and Penny Lane Centers; and youth representatives of Centro Community Hispanic Association, Inc., South Central Youth Empowered through Action, and New Visions Foundation. The Commission held one public hearing on best practices at which the following organizations were represented: Tennessee Department of Children's Services; Michigan Department of Human Services; Casey Family Programs; Five Points Technology Group, Inc.; Allegheny County Department of Human Services in Pennsylvania; and Eckerd, the Lead Agency in three Florida Counties. The Commission also received important comments from many members of the public.

- **Interviews with more than 300 stakeholders** across all program areas related to child safety. Under the direction of a Commission work group and with significant support from community-based organizations and agencies, the University of Southern California School of Social Work took primary responsibility for organizing and conducting these interviews. Interviews were conducted in each Supervisorial District and included conversations with representatives of DCFS, the Dependency Court, DHS, DPH, the Commission for Children and Families, Service Employees International Union leadership, selected local hospitals and community health services, Los Angeles and

Long Beach Unified School Districts, faith-based organizations, and community nonprofit programs contracting with DCFS, DMH, and the Department of Probation. Interviews were conducted with providers representing a complete spectrum of services, ranging from prevention, early diagnosis and investigation, to foster care, intensive treatment, residential care, and transitional support. A total of 313 persons provided input in one of either 35 focus groups or 38 in-person meetings.

- **Focus groups with the people most impacted by the policies and practices of the child welfare system.** Under the direction of another Commission work group with significant support from Casey Family Programs and the USC School of Social Work, focus groups and interviews were conducted with the following client populations: children and youth 13-17 years old; transition age youth 18-25 years old; LGBT youth; formal and informal kinship caregivers; birth parents; and foster and adoptive parents.

- **Review of relevant previous recommendations made to DCFS and other County agencies.** In consultation with Walter R. McDonald & Associates, Inc. (WRMA), a database was created to organize and categorize prior recommendations related to child protection and safety dating back to 2008. About 800 recommendations contained in 29 documents were reviewed and analyzed.

- **One-on-one, in-depth interviews with leaders in the child welfare field, conducted by Commissioners and Commission staff.** These included extensive interviews with members of law enforcement, DCFS, DHS, DMH, and the District Attorney's Office, as well as many community and academic leaders.

- **Review of best practices and relevant reports on child abuse.** The Commission reviewed promising practices and reports considered and/or utilized in other jurisdictions to assess what can be learned and applied in Los Angeles County. It also drew important information from state and local databases and academic studies and articles.

- **Constituent correspondence received by the Commission.** Constituent letters and email inquiries were reviewed and incorporated, where appropriate.

- **Review of individual child fatality case files pursuant to an Order granted by the Presiding Judge of the Juvenile Court.** The Commission reviewed the 25 most recent child fatality cases in Los Angeles County, determined by DCFS to have been caused by child abuse or neglect, as well as the cases of Gabriel F., Dae'von B., and Erica J.

APPENDIX 2

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Blue Ribbon Commission on Child Protection

Client Feedback in LA County:

Final Report

February 2014

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Introduction

This report was completed at the request of the Los Angeles County Blue Ribbon Commission for Child Protection (BRC), to summarize results and recommendations from a series of focus groups and interviews conducted with client populations in Los Angeles County who have been involved with, or provide support to the child protection and foster care systems. The BRC has spoken with many groups who have experiences with how the County as a whole protects children and keeps them safe. This report describes the experiences of the following client groups: (1) Foster youth (under age 18); (2) Transitional age youth (age 18-24); (3) Lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) youth (age 18-24); (4) Birth parents; (5) Kinship caregivers; and (6) Adoptive/ foster parents.

This report includes three parts: (1) Context for the BRC's work; (2) Review of qualitative literature for each population; (3) Themes from client focus groups and interviews conducted by the BRC team and representatives, including recommendations on ways the County as a whole can better protect children and keep them safe.

I. Context for the Blue Ribbon Commission's Work

Blue Ribbon Commission on Child Protection

On June 25, 2013, the Los Angeles County Board of Supervisors created the Blue Ribbon Commission for Child Protection, following the tragic death of eight year-old Gabriel Fernandez. The BRC was asked to provide an independent perspective on County-wide solutions to improving child safety. In its motion, the Board charged the Commission to:

- Review previously delayed or failed efforts to implement reforms and provide recommendations for a feasible plan of action to expeditiously implement needed reforms;
- Review the systemic, structural and organizational barriers to effective performance. These may include such factors as the current structure, scope of the Department of Children and Family Services (DCFS) and relevant County departments, including the Departments of Health Services, Mental Health, Public Health, the Sheriff, the District Attorney, the Dependency Court and commissions, various memoranda of understanding, and the relationship of DCFS to the Board; and
- Review, at its discretion, the child protection failures, including DCFS policies and cases.

As part of the BRC's work, it has identified that an important component of reviewing the systemic, structural and organizational barriers to effective performance, includes speaking directly with families and youth who are most impacted by County services. Interviews and focus groups were conducted in order to better understand their perspectives regarding child safety issues and the ability of services to impact child safety. Commissioner Janet Teague is responsible for this task of the Commission's work, and has provided leadership and direct assistance in completing this task.

Process of Gathering Information

The BRC's process of gathering client feedback was informed by the following set of questions:

- From a family, community, and systems perspective (including biological parents, foster parents, kinship caregivers, children/youth, community based organizations and relevant County agencies), what is needed to keep children and youth safe?
    - What child safety concerns led to system-involvement?
    - What could have prevented those child safety concerns?
    - How did the system respond to help to address child safety concerns, and how could it have improved its response?

These questions, as well as a literature review on qualitative published research, guided the development of focus group protocols for each of the five client groups. The literature review found common themes regarding child safety, as identified by the different client populations through interviews and focus groups. These common themes helped to place the experiences of Los Angeles County clients into perspective, compared with broader issues identified in child welfare systems at a national-level.

During the planning stage Walter R. McDonald & Associates obtained an Institutional Review Board (IRB) waiver ensuring that that these focus groups are not subject to the IRB process. The questionnaire protocols used for focus groups introduce the purpose of the BRC and the focus group, offer guidelines on confidentiality, and present customized questions regarding child safety, services, and recommendations for each client group.

Commissioner Teague and the BRC team (including BRC staff, the USC School of Social Work and Casey Family Programs) conducted a total of 18 focus groups and 13 individual interviews, speaking with a total of 172 individuals from various geographic areas throughout the County (See the table below for additional detail for each population). The BRC worked with several attorneys who offered their services on a pro-bono basis; they attended the focus groups, took notes, and compiled notes into a memo document, in order to protect client confidentiality. Qualitative analysis was conducted using the focus group notes memo, and the themes and recommendations described below emerged from that process.

Client Population	Focus Group Participants	Interview Participants	Sample Size
Foster Youth (Under Age 18)	11	2	13
Transitional Age Youth (Age 18-24)	27	2	29
LGBTQ Youth (Age 18-24)	15	0	15
Birth Parents	35	5	40
Kinship Caregivers	65	2	67
Adoptive/ Foster Parents	6	2	8
Totals	159	13	172

II. Review of the Qualitative Literature

Foster Children and Youth

A literature review of qualitative studies done with foster children and youth, as well as children and youth living in kinship care, found several common themes pertaining to the physical and emotional safety of children and youth in the child welfare system. The studies reviewed used both focus groups and individual interviews to obtain the perspectives of children and youth who have experienced out-of-home placements (foster homes, kinship homes, group homes, residential treatment, and transitional living programs). Throughout the literature, the majority of children and youth described their out-of-home placement as safer and more stable than the home of their birth family (Fox & Berrick, 2007; Fox, Berrick, & Frasch, 2008; Dunn, Culhane, & Taussig, 2010). Even children as young as 4 years old were able to describe the safety concerns that brought them to care and how their out-of-home placement was safer than living in their birth home (Winter, 2010). However, the perspective of children and youth on safety differed based on the type of out-of-home placement in which they were living. Children living in family foster homes and kinship homes rated their safety and well-being as higher than those placed in residential settings (NAIARC, 2005; Fox & Berrick, 2007; Fox, Berrick, & Frasch, 2008; Dunn, Culhane, & Taussig, 2010).

Children and youth described concerns surrounding their emotional safety, reporting out-of-home care providers or another person within the out-of-home placement yelling within the house and saying hurtful comments (NAIARC, 2005; Fox, Berrick, & Frasch, 2008). Children and youth also reported feelings of confusion, sadness, loss, and anxiety when removed from birth families and placed in-out-of home care (Dunn, Culhane, & Taussig, 2010; Winter, 2010). Children and youth in kinship care described less emotional strain over the transition into out-of-home care due to the stability and normalcy of being placed with relatives (NAIARC, 2005).

Another common safety theme identified by children and youth throughout the literature is neighborhood safety. Children and youth living in out-of-home placement reported feeling an increase in neighborhood safety compared to birth families' homes, but still described significant concerns about the safety of their neighborhoods (NAIARC, 2005; Fox & Berrick, 2007; Fox, Berrick, & Frasch, 2008). Children and youth described witnessing high rates of neighborhood violence, being victims of neighborhood violence, and feeling unsafe walking around the neighborhood of their out-of home-placements (Fox, Berrick, & Frasch, 2008).

A review of two reports produced by the California Youth Connection (CYC) found several common themes among the recommendations. These recommendations for improving the child welfare system and other services utilized by foster youth were created by foster youth living in Los Angeles and several other California counties. Recommendations regarding physical safety included:

- More training for social workers and foster parents on the needs of older youth and transition aged youth (CYC, 2001; CYC, 2006);
- More monitoring and training for group home providers to increase safety in group homes (CYC, 2006);
- Smaller and more specialized caseloads for county social workers in order to provide more frequent and meaningful interactions (CYC, 2001) and;
- More access to safe housing in safe and resource rich neighborhoods for foster youth and transition aged youth (CYC, 2001; CYC, 2006).

Recommendations regarding emotional safety included:

- Increased resources to birth families and kinship caregivers to prevent out-of-home placements and to increase the utilization of relative placements (CYC, 2006);
- Increased access to quality mental health services (CYC, 2001; CYC, 2006); and
- Increased monitoring and oversight of psychotropic medications to reduce over prescribing and to better understand how behaviors are related to the emotional stress of out-of-home placements (CYC, 2001; CYC, 2006).

Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBTQ) Youth in Foster Care

A literature review of qualitative studies done with foster youth who identify as gay, lesbian, bisexual, transgendered, or questioning (LGBTQ) found several common themes pertaining to the physical and emotional safety of LGBTQ youth in the child welfare system. The studies used both focus groups and individual interviews to obtain the perspectives of LGBTQ youth who have experienced out-of-home placements (foster homes, kinship homes, group homes, residential treatment, and transitional living programs). The literature shows that LGBTQ foster youth report experiencing harassment and physical assaults; discrimination in the provision of child welfare, health care and mental health services; and fear, rejection, and social isolation due to their sexual orientation. All of these factors lead to LGBTQ foster youth experiencing a greater rate of homelessness, and therefore exposing them to all the safety concerns that come along with youth homelessness. The LGBTQ foster youth represented in the literature also describe some positive interactions with the system. Some social workers and foster parents are described as affirming and strong advocates (Gallegos, White, Ryan, O'Brien, Pecora, & Thomas, 2011; Casey Family Programs, 2007; CWLA & Lambda Legal, 2006; Mallon, Aledort, & Ferrera, 2002; Mallon, 1998) and services that are specifically geared at serving LGBTQ youth, such as LGBTQ group homes, are described as accepting and effective in providing caring and safe services (CWLA & Lambda Legal, 2006; Mallon, Aledort, & Ferrera, 2002; Mallon, 1998). However, the majority of LGBTQ foster youth describe some negative experiences while in care, directly related to their sexual orientation.

Harassment and Physical Assaults

LGBTQ foster youth report experiencing harassment based on their sexual orientation within their biological families, foster families, group home placements, and communities. The harassment includes the use of derogatory names, judgments based on religious beliefs, destruction of personal property, and threats of physical violence (Gallegos et. al, 2011; HHYP, 2001; Ragg, Patrick, & Ziefert, 2006; CWLA & Lambda Legal, 2006; Mallon, 2001; Mallon, 1998). LGBTQ foster youth reported that this harassment has come from peers, foster parents, and group home staff.

LGBTQ foster youth reported that at times the harassment escalated to physical assaults, discussing instances of physical beatings, burns, poisoning of food, and sexual assaults (CWLA & Lambda Legal, 2006; Freundlich & Avery, 2005; Mallon, 2001; Mallon, 1998). These physical attacks have been reported in biological homes, foster homes, group care settings, and in the neighborhoods in which youth are placed. LGBTQ foster youth describe staff and case workers as ignoring the harassment and/or dismissing the harassment as being the youth's fault for disclosing their sexual orientation (Ragg, Patrick, & Ziefert, 2006; Freundlich & Avery, 2005;

Mallon, 2001). As a result of the harassment and lack of safety provided within the system, LGBTQ foster youth describe being moved multiple times and experiencing higher rates of placement instability (HHYP, 2011; CWLA & Lambda Legal, 2006; Ragg, Patrick, & Ziefert, 2006; Freundlich & Avery, 2005; Mallon, Aledort, & Ferrera, 2002) .

Discrimination in Service Provision

Throughout the literature, LGBTQ foster youth describe discriminatory practices in child welfare services. Common discriminatory practices described are those related to the disclosure of their sexual orientation. LGBTQ foster youth describe instances of judgment by caseworkers, foster parents, and group care workers based on their personal beliefs on sexual orientation (Ragg, Patrick, & Ziefert, 2006; Mallon, Aledort, & Ferrera, 2002; Mallon, 2001). They also describe the negative effects of having their sexual orientation be put into their permanent file and disclosed to others in the system without their permission (Ragg, Patrick, & Ziefert, 2006).

LGBTQ foster youth also report that caseworkers, foster parents, and group home staff often over sexualize their behavior based on their sexual orientation. Behaviors such as holding hands and kissing are viewed as age appropriate for heterosexual youth but discouraged or even labeled as sexually aggressive for LGBTQ youth (CWLA & Lambda Legal, 2006; Ragg, Patrick, & Ziefert, 2006; Freundlich & Avery, 2005;). This labeling of normal behavior as abnormal can be harmful to the sexual development of LGBTQ foster youth and discourage LGBTQ foster youth from seeking out resources for safe sex. In foster homes and group homes, LGBTQ foster youth report that they are often placed in isolated rooms or refused services and moved because of the misconception that they will attempt to engage in sexual activity with their same sex roommate or foster sibling (CWLA & Lambda Legal, 2006; Ragg, Patrick, & Ziefert, 2006; Freundlich & Avery, 2005; Mallon, 2001).

LGBTQ foster youth also describe discriminatory practices in both physical and mental health service provisions that put their physical and emotional safety at risk. They report a lack of access to doctors and counselors who specialize in LGBTQ health issues which can lead to misinformation about sexual and reproductive health and non-affirming mental health services (CWLA & Lambda Legal, 2006; Mallon, Aledort, & Ferrera, 2002; Mallon, 1998). Transgendered foster youth reported discrimination in health care services specifically related to the rejection of their gender identity and a lack of access to safe hormone treatments (CWLA & Lambda Legal, 2006; Mallon, Aledort, & Ferrera, 2002).

Fear, Rejection, and Social Isolation

LGBTQ foster youth commonly report living in a state of fear for their physical and emotional safety due to their sexual orientation and feeling like they must hide who they really are (Gallegos et al., 2011; CWLA & Lambda Legal, 2006; Ragg, Patrick, & Ziefert, 2006; Mallon, 2001; Mallon, 1998). Some LGBTQ foster youth describe going to extreme measures, such as pretending to date someone of the opposite sex or even harassing openly gay youth, to hide their own sexual orientation (CWLA & Lambda Legal, 2006; Mallon, 2001; Mallon, 1998). The fear and anxiety around hiding their sexual orientation leads to feelings of rejection by the system and social isolation, putting LGBTQ foster youth at higher risk for leaving the system and facing homelessness and further victimization and health risks on the streets (CWLA & Lambda Legal, 2006; Ragg, Patrick, & Ziefert, 2006; Mallon, 2001; Mallon, 1998).

Homelessness

The Los Angeles Homeless Services Authority's Homeless Point in Time Count, a one night count of individuals experiencing homelessness conducted in January of 2013, found 6,019 homeless youth in Los Angeles; 5,202 were transitional aged youth ages 18-24 and 817 were unaccompanied minors under the age of 18 (LAHSA, 2013). In 2011, Hollywood Homeless Youth Partnership (HHYP) and Los Angeles Children's Hospital utilized surveys, interviews, and focus groups to speak with close to 400 homeless youth in Hollywood, CA. The study found that 45% of homeless youth identified as LGBTQ and 48% of homeless youth reported involvement with Child Protective Services at some point in their lives, with 40% reporting an out-of-home placement (HHYP, 2011). Throughout the literature, LGBTQ foster youth describe the failure to provide placements that are free of harassment and physical assaults as the reason for why they run away and become homeless at much higher rates than other youth (CWLA & Lambda Legal, 2006; Freundlich & Avery, 2005; Mallon, 2001; Mallon, 1998). Once on the streets, LGBTQ foster youth report serious safety issues including: verbal harassment, physical assault, sexual exploitation and rape, intimate partner violence, and exposure to drugs (HHYP, 2011; CWLA & Lambda Legal, 2006; Mallon, 1998). LGBTQ foster youth also report similar safety concerns and discrimination in housing services as reported in child welfare services, including harassment and assaults in shelters, discriminatory mental health services, and refusal of services due to sexual orientation (HHYP, 2011; CWLA & Lambda Legal, 2006; Mallon, 1998).

Birth Parents

Birth parents are most often the identified client within child welfare systems, yet rarely do systems, or the larger field of research, collect feedback on how the system is meeting consumer needs. In general, there has been a lack of interest or priority placed on eliciting the experiences and perspectives of biological parents involved with child welfare in the United States, and the state of this literature reflects such lack of curiosity (Baker, 2007). However, the U.S. qualitative studies that do exist can be supplemented with studies from Canada and the United Kingdom, which seem to have placed greater priority on this population. Although these countries' systems of child protection are different from the U.S. system, the points of view expressed by these parents are largely consistent with what we know from U.S. parents, and provide greater elaboration on specific needs experienced by families. While this summary seeks to provide information on the particular needs and services related to improving child safety in biological homes, it is important to consider that parents do not necessarily attach the same meanings to the concept of safety as do child welfare workers and the larger system (Gladstone et al., 2012). Therefore, parents' self-identified needs often do not align with how service systems identify needs and provide services for the purposes of ensuring child safety (Brown, 2006; Dale, 2004; Kapp & Propp, 2002).

The primary self-identified needs of biological parents include:

- Financial resources/ concrete goods (Bolen, McWey, and Schlee, 2008; Brown, 2006; Dumbrill, 2006),
- Managing child behavior problems/ aggression (Bolen, McWey, and Schlee, 2008; Brown, 2006; Dale, 2004), and
- Help raising teenagers (Bolen, McWey, and Schlee, 2008; Brown, 2006).

Additional identified needs included child development issues, poor child school performance, parent substance problems, parent support groups (Bolen, McWey, and Schlee, 2008), preventive services, crisis support, and respite foster care (Dale, 2004). Parent support groups were seen as a method to get help in a non-judgmental, non-stigmatizing way, helping parents

to become less socially isolated. In general, parents' needs were more preventive in nature, as one worker described: "A lot of times what the client identifies as what they need is going to be a child protection concern later. It's your prevention in action (Brown, 2006, 362)." Many parents indicated that they had sought help prior to Child Protective Services (CPS) involvement (Dale, 2004; Dumbrill, 2006), and the need for intrusive intervention could have been avoided if their requests for help had been answered sooner (Brown, 2006). Of responding parents, most agreed that everyone needs help with parenting (Keller & McDade, 2000), but a disconnect existed between this help-seeking orientation and sources that parents trusted for accessing reliable and non-threatening help. Among 52 low-income parents in King County, Washington, they cited Child Protective Services as the least likely source of help with parenting, with 0% of respondents indicating they would choose to seek help with parenting issues from CPS (Keller & McDade, 2000).

The views of biological parents regarding services or interventions to improve child safety were especially unique, shedding considerable light upon their largely powerless status in the midst of a powerful system. The perceived helpfulness of CPS to parents was mixed; in the UK, 50% of families reported some positive benefit, and another 50% reported that the intervention did not help, or had caused them harm (Dale, 2004). In Florida, a study found that 57% of parents reported that CPS involvement had no effect on their children's behavior, while 31% said behavior improved (The Florida Legislature, 1998). Reflecting their disadvantaged status within a larger power dynamic, parents often found CPS involvement to be frustrating, confusing, traumatic, disempowering, and requiring feigned cooperation to maintain connections with their children. One study found power to be the primary influence shaping parents' views of CPS intervention and their reaction to it (Dumbrill, 2006). All parents regarded CPS as far more powerful than themselves, and they perceived that power could be used over them as a form of control, but also that power could be used with them as a form of support, varying at the worker's discretion. In reaction to this power imbalance, parents either fought workers by openly opposing them (though few parents chose this response due to the considerable power of CPS), or "played the game" by feigning cooperation (Dumbrill, 2006). Other studies referenced "playing the game" as well, indicating that this response is widely utilized, even across multiple countries (Brown, 2006).

Parents were often especially concerned with threats to their children's physical and emotional safety, not necessarily from their own home environment, but from CPS itself. "[Child Welfare Agency] keep saying they're there for the children, but they really do not take the children into consideration whatsoever. They take everything *you* do into consideration, not those children. It's you that has to take those kids into consideration (Brown, 2006, 368)." Parents were deeply distrustful of CPS intervention, and once trust had been broken (often from the initial visit to the home), it became very difficult to reestablish (Altman, 2008). Engaging parents in a meaningful way heavily depended upon building or reestablishing trust (Altman, 2008; Gladstone et al., 2012), and one study found that parents who were more engaged were more likely to feel that their children were safer as a result of CPS intervention (Gladstone et al., 2012). For parents to benefit from services, they highlighted the importance of developing a helping-alliance, for workers to be "on their side" and advocate for their family's self-identified needs and goals within the system (Altman, 2008; Gladstone et al., 2012). To achieve successful engagement, parents also emphasized the importance of individualized service planning and culturally competent approaches (Bolen, McWey, and Schlee, 2008).

Kinship Caregivers

Although there is an extensive amount of research around the outcomes of children raised in kinship care as compared to foster care, there is a shortage of qualitative studies about kinship caregivers' experiences raising their relative's children. This literature review summarizes four qualitative studies that conducted focus groups with informal and formal kinship caregivers in multiple jurisdictions between 2003-2013. The common themes that emerged across the focus groups are summarized below.

The primary safety concern raised by kinship caregivers was related to parental substance abuse and the need for child welfare agencies to provide better treatment services for birth parents. (Gordon, 2003; Lawrence-Webb, 2006). Caregivers discussed the lack of substance abuse treatment services and their concern about how exposure to substance abuse would negatively impact the emotional and psychological well-being of their kin in the future. Many expressed unease about what would happen to these children once they were adults and wished that the child welfare agency could provide better quality mental health services for the youth (Wilder Research, 2012; U.S. Department of Health and Human Services, 2001).

Throughout the focus groups, kinship caregivers also described feeling a lack of respect by the child welfare agency workers and a sense of mistrust with child welfare and other social services agencies. They believed that they were often treated as "babysitters" rather than partners by the child welfare agency and wished that they were more involved in the case decisions around permanency (Gordon, 2003; Lawrence-Webb, 2006). Caregivers commented that high worker turnover led to confusion about their legal options and a lack of information about where to go for resources and services (Gordon, 2003; Lawrence-Webb, 2006; Wilder Research, 2012; U.S. Department of Health and Human Services, 2001).

In addition, kinship caregivers described a need for more concrete services, as many of them are older and on a fixed income (Lawrence-Webb, 2006; Wilder Research, 2012; U.S. Department of Health and Human Services, 2001). They expressed frustration that the child welfare system did not understand the difficulties they experienced and the support systems that would help them become independent while caring for their children (Lawrence-Webb, 2006). They requested more affordable legal aid to help them navigate through the complex legal system and explore permanency options. They also expressed a need for respite care or child care so that they could have some time for themselves as well as informal supports like peer support groups. (Lawrence-Webb, 2006; U.S. Department of Health and Human Services, 2001).

Foster and Adoptive Parents

Although foster parents have a wealth of experience working with child welfare systems and caring for the children that have been placed in their homes, there is a lack of research that solicits their perspective and insight regarding what is necessary to keep the children in their care safe. This literature review summarizes five qualitative research studies which conducted focus groups with foster and adoptive parents in multiple jurisdictions between FY 2002-2013. Similar themes emerged across the focus groups; these themes are summarized below.

Respite care and child care were the two most commonly cited services needed by foster parents (Connecticut Department of Children and Families; 2008, Alaska Department of Health

and Social Services, 2008; U.S. Office of Inspector General, 2002; Child Welfare Initiative, 2013). They portrayed these services as paramount because they allow foster parents to work, complete other activities, and take a break from the stress that accompanies foster parenting. Better access to mental health services was also identified as a need by foster parents, especially for the adolescents in their care (Connecticut Department of Children and Families, 2008; U.S. Office of Inspector General, 2002; Houston, D., 2007). In some of the focus groups, foster parents requested more training specific to adolescents' behavioral issues (Connecticut Department of Children and Families; 2008). Foster parents also requested better access to medical and behavioral health records and a clearer understanding of the needs of the children being placed in their care (Connecticut Department of Children and Families; 2008, Alaska Department of Health and Social Services, 2008; U.S. Office of Inspector General, 2002; Child Welfare Initiative, 2013; Houston, D., 2007). Foster parents felt that often they were not adequately prepared for the needs of the child placed in their care because they were not told about the full extent of the child's needs in advance or adequately trained to handle those needs.

All of the focus group studies highlighted the lack of support by the child welfare agency towards foster parents and difficulty communicating with them. Foster parents felt that they were not always respected by the child welfare agency and tended to be left out of important decisions concerning the child, such as placement decisions (Alaska Department of Health and Social Services, 2008; Office of Inspector General, 2002).They wished that they were more valued as members of the team and included as a partner in decision-making around the case. They also expressed concern over high caseworker turnover and the disruptive impact that it had on the children. Foster parents reported that they found it difficult to build positive working relationships when new workers were constantly being assigned to the children in their care (Connecticut Department of Children and Families; 2008; Alaska Department of Health and Social Services, 2008; U.S. Office of Inspector General, 2002).

Foster parents did appreciate the opportunity to belong to a foster parent support group, which allowed them to network and share experiences with other foster parents that were encountering the same challenges as themselves (Alaska Department of Health and Social Services, 2008; Child Welfare Initiative, 2013). Most of the participants were also satisfied with the monthly stipend for the younger children but some felt that they needed more financial resources to cover all of the expenses of the teenagers in their care (Alaska Department of Health and Social Services, 2008).

III. Themes from Client Focus Groups and Interviews

Themes from Foster Youth (Under Age 18)

The following themes were developed from qualitative analysis of documentation from focus groups and interviews that the BRC team conducted with foster youth (13-17 years old) in Los Angeles County.

Youth Definitions of Safety:

To begin the focus group discussion, facilitators asked the youth to share their thoughts on what it meant to feel safe and unsafe. Facilitators mentioned that the focus group questions will be asking about both their physical and emotional safety, and so it would be helpful to have a shared understanding of what safety means. Foster youth participants shared the following descriptions of what "safety" felt like: protected, surrounded by people who care about you, you feel healthy, enough food, not hurting yourself, mentally safe, sanitary conditions, loved, feel caring, respect, responsibility, with someone you can trust and talk to, and not feeling like everyone is doubting you or thinking mean things about you. Participants also gave the following descriptions of "unsafe": harm, taken advantage of, not wanted, dark places (emotionally), abusive, non-caring, treated unfairly, not knowing, being unsure of what is going to happen, yelling, police, sirens, guns, bullies, drugs, gangs, things that will make you run, and feeling other people get hurt.

Settings Where Youth Felt Safe

When asked about the places where youth felt safe, they described experiences in their biological homes and foster care placements. Among the focus group participants, youth shared that they felt safest in foster family homes, followed by their biological homes, and they felt the least safe in group homes. Note that some youth felt safe in more than one place, while others did not feel safe anywhere. As a result, the total number of instances is larger than the sample size of 13. Also, note that questions focused on biological homes, foster family homes, and group home facilities; questions did not focus on kinship placements, and therefore totals for kinship are not included here. Youth shared that they felt safe in the following places:

- Foster family home (8 instances),
- Biological home (5 instances), and
- Group home (2 instances).

> **"When I can't sleep, I sleep in my [foster] mom's bed. It makes me feel safer."**

Safety Issues in Various Settings

When sharing their experiences in their biological homes and in foster care youth described numerous unsafe situations. Youth described the most unsafe situations from their biological family homes, followed by foster family homes, and then group home facilities. It is notable that youth described that they most often felt safe in foster homes (detailed above), and yet safety issues were identified 10 times in foster families. By contrast, youth identified group home safety issues only 8 times, yet they rarely felt safest in group homes. Such seeming contradictions may instead indicate that youth felt safest in a home-like family environment, even in the presence of safety threats, although they were not specifically asked about this. Meanwhile, youth felt less safe in group homes, even in the absence of obvious safety concerns. Participants described safety issues in the following environments (note that multiple issues overlapped, and so the individual incidents sometimes summed to more than the total):

- Biological home (14 instances)
  - Including: physical abuse (7 instances), substance abuse/ criminal activities (7 instances), lack of food/ electricity (1 instance), domestic violence (1 instance), and sexual abuse (1 instance).
- Foster family home (10 instances)
  - Including: sexual abuse (4 instances), attempted murder/ murder threats (from either the foster parent or foster siblings) (3 instances), physical abuse (2 instances), and gang activities in the home (1 instance).
- Group home (8 instances)
  - Including: physical assaults from other residents (2 instances), medical neglect (2 instances), threats of sexual assault (1 instance), locked out of the facility (1 instance), lack of food (1 instance), dangerous interactions of medications (1 instance).
- Safety threats in the community (6 instances)
  - Including: drugs/ gang activities (2 instances), general feelings of neighborhood unsafety (2 instances), fears of rape (1 instance), and fears of burglary (1 instance).

"I was raped and abused in my foster home. They are supposed to be protecting us because my parents didn't."

Helpfulness of System Response or Services

Overall, youth described a total of 91 unhelpful services or actions taken by caseworkers, group home staff, foster parents, and service providers/ professionals. By contrast, they described only 36 helpful services or actions taken by these groups that were responsible for their care, indicating that foster youths' experiences with the system have been largely negative. Helpful system responses or services included (Unhelpful system response descriptions are provided below, under caseworker and group home staff interactions):

- Foster home treats them well (10 instances),
- Individual counseling (7 instances),
- Group home staff demonstrate caring and support a healthy environment (5 instances),
- Wraparound services (3 instances),
- Youth's attorney was a strong advocate (3 instances),
- ILP worker was helpful (3 instances),
- Family/ couples counseling (2 instances),
- Drug treatment program (1 instance), and
- Removing the youth from biological home saved the youth's life (1 instance).

"I think foster care is pretty cool. I have a good mom, guardianship, I've had a good experience. I know some others are not very good. I'm pretty lucky for that, a lot of kids don't get that."

Caseworker and Group Home Staff Interactions

Foster youths' interactions with DCFS caseworkers and group home staff were particularly negative. Negative caseworker interactions (18 instances) were described with much greater frequency than positive interactions (2 instances). Similarly, Negative interactions with group home staff outnumbered positive interactions (21 to 4 instances, respectively). Negative caseworker interactions fit into the following categories:

- Safety issues were not properly investigated by social worker when youth reported the concern, or a general lack of oversight of the placement (6 instances),
- Negative interactions with the caseworker in general/ did not trust them (5),
- Lack of communication or follow-through (4 instances), and
- Did not connect the youth to services or inform them of service availability (especially ILP) (4 instances).

Negative group home staff interactions include the following:

- Staff did not listen, violated trust, or did not seem to care in general (7 instances),
- Staff triggered youth to get them punished, or brought their own problems to the group home (5 instances),
- Staff disregarded youth identified concerns or allegations (4 instances),
- Verbal harassment from staff (4 instances), and
- Lack of help with independent living skills (2 instances).

"Whenever you need something, the social worker takes forever to get back to you. I leave a lot of messages, but they don't call you back, unless they see you again. You go around in a circle with them."

Taking Youths' Concerns Seriously

Many youths had experiences where responsible adults (including caseworkers, foster parents, group home staff, and other professionals) did not take their concerns or allegations seriously. Not taking their concerns seriously was mentioned 13 times, and was reported in focus groups for the following types of concerns:

- General problems in the group home/ foster home, or that adults do not believe youth in general (5 instances),
- Physical assault from other residents/ foster siblings (1 of these included a sibling pulling a knife on the youth) (4 instances),
- Physical abuse from the birth parent (1 instance),
- Threats of sexual assault (1 instance).

"I get a lot of abuse from girls in the group home and staff does not even acknowledge it; and I look up to them because I have no parents, and they don't even respect me enough to help."

"At another group home, I was punched by other residents and the staff claimed they "didn't see anything.""

"We were telling the social worker before that we're about to run away because of this, and nothing was done. So, we ran away."

Real versus "Fake" Caring

Numerous youths expressed that they did not believe that foster parents or group home staff were providing them with care because they genuinely cared. Instead, these youths' were suspicious that foster parents and staff were only involved "because of the money," and a lack of care or concern as a result of this was mentioned 7 times. Youths discussed that this general feeling of lack of concern for their well-being by the adults present in their life made it difficult for them to trust others and improve in their life.

> **"Kids run away when they think the adults don't care about them."**

Foster Youth (Under Age 18) Recommendations

The following recommendations were either mentioned explicitly by foster youth during focus groups as ways to improve their experience and how the system responds to their needs, or the recommendations emerged from the above themes, as primary issues that deserve greater attention from the County.

Recruitment and Development of Professionals Who Care about the Well-Being of Youth

1. Improve screening processes for foster homes and group home staff. Improvements in screening were actually identified by youth in 4 separate instances, indicating this is a widespread concern that youths themselves are requesting. Additionally, youths have also identified that professionals and parents who work with youth need to be more caring. This was mentioned as a recommendation a total of 7 times. Given youths' concern about hiring the best professionals who are competent, qualified, and above all—caring for youths' well-being, the County should carefully re-examine and restructure its recruitment and professional development processes, whereby particular characteristics and skills are prioritized. The most important characteristic (according to youth), is that the professionals genuinely care for youth and are passionate in helping them to succeed. Skill-development should be based around active listening, identifying safety concerns, and taking action expediently and in an appropriate manner regarding such concerns.

Improving System Response and Caseworker Interactions

2. The County should expand the role of the older youth ombudsman, and have an ombudsman in each County office, serving to consistently respond to concerns and complaints made by youth in care, as well as other client populations. Ombudsman staff should include objective professionals who can look at the data without taking sides and analyze the situation without simply relying on the story of DCFS or others. Additional mechanisms of system accountability that prioritize youths' voice and sense of control over their own lives should be developed.

3. Oversight of both foster homes and group homes should be prioritized and intensified. The current processes in place to ensure that placements meet the physical and emotional needs of youth are inadequate. Licensing inspections should be carried out multiple times per year, should be unscheduled, and should include interviews conducted with youth in private to better address their self-identified allegations and concerns. Additional plans for oversight and monitoring of youth placements ought to be

developed as well.

Access to Services and Activities that can Improve Youth Outcomes and Engagement

4. While some youth expressed satisfaction and have benefited from ILP services, many eligible youth were unfamiliar with ILP, or had requested such services without any follow-through by DCFS. ILP services should be expanded, in both the array of services available, as well as the outreach to eligible youth. Additionally, one youth expressed disappointment that he was no longer eligible for ILP, as he achieved permanency. Consider expanding ILP eligibility to include any youth who experienced foster care after the age of 14.

5. Several youth mentioned the importance of providing them with opportunities to be active with sports and other activities that they can focus on outside of the foster home. Youth need to be engaged in activities they care about, which can facilitate growth in many domains of their lives, and help them to reduce their level of care and achieve permanency. The County should connect with local sports leagues and other activities in the community, and provide youth with a listing of local opportunities that might fit with their interests and goals.

Additional Focus Group Recommendations

The Strategic 1.4.3 Workgroup conducted a parallel set of focus groups of current foster youth in LA County in 2013. This workgroup was charged with developing a plan to reduce the percentage of youth in care three years or longer by 10%. This workgroup also described a set of youth identified recommendations, which included:

1. "*CSWs should want to work with kids."*

2. *"We should be more involved in our cases—I wanted to stay in my placement but I was moved to another one. I had no control."*

3. *"Why can't my CSW and her supervisor just answer the phone? I keep trying and they are not there." Another youth suggested that this girl contact the Ombudsman. "My social worker did not visit me for three months, I called the Ombudsman and my social worker was there the next day."*

4. *"I think we should rate our social workers so there supervisors can see if we are having trouble with them. Like in college how you can rate your professor."*

Themes from Transitional Aged Youth

The following themes were developed from qualitative analysis of documentation from focus groups and individual interviews that the BRC team conducted with transitional aged youth in Los Angeles County.

Settings Where Youth Felt Safe

Youth self-identified settings where they felt safe, protected, and secure in their lives. These settings included:

- Feeling safe in foster homes –youth reported that they were placed in foster homes with caring and loving foster parents, making them feel safe and secure (9 instances), Feeling safe in their bio-home – youth talked about feeling emotionally safe and loved when they were with their biological families (5 instances), and
- Feeling safe in group homes – youth discussed feeling safe in group homes due to caring staff and the structure provided within the home (2 instances).

Safety Issues While in Care

Self-identified safety needs were discussed throughout the focus groups and interviews conducted with transitional aged youth (30 instances). These safety concerns are broken into issues reported in foster homes, group home, and bio-parent homes.

> **"There is never a time you can be safe inside of foster care because you never know that person they placed you with is going to come into your room and touch on you. It's not a safe surrounding being in foster care. They are not our family so they are not going to care if something happens to us. There are no safe surroundings in foster care because you have to watch your own back."**

Safety Issues in Foster Homes

- Neglect (4 instances), physical abuse (3 instances), emotional abuse (3 instances), and sexual abuse (1 instance)
- Feeling that foster parent only provided the "bare minimum" in order to receive county foster care payments and did not truly care for or love the children in their home (8 instances), and
- General feelings of never feeling safe in foster care; several youth reported there was not a single time they felt safe while in a foster home (6 instances).

Safety Issues in Group Homes

- Bullying, harassment, and/or physical assaults perpetrated by other youth living in the group home (5 instances) and
- Neglectful (2 instances) and abusive (2 instances) behavior perpetrated by group home staff.

Safety Issues in Birth-Parent Home

- Physical abuse and/or neglect by birth parent (4 instances), and
- Substance abuse issues (3 instances)

"I am the type of person I don't care if you are right there or not, if you are hurting me I am telling. So still reported it but I stayed with her [foster mother] for another year after I reported it several times. If they [caseworker] don't do anything about it what am I supposed to do? I run away, I get in trouble. I can get sent to a boot camp or placement group home. I don't want to get sent to that because I couldn't stay in my foster home because they abused me."

Worker Interactions

Transitional Aged Youth reported a mix of positive experiences (11 instances) and negative experiences (27 instances) with workers they interacted with while in the child welfare system. The workers included CPS workers, caseworkers, transitional coordinators, and group home staff. The interactions have been grouped into positive and negative interactions with DCFS workers (CPS, ongoing caseworkers, and transitional coordinators) and positive and negative interactions with private group home workers.

Interactions with DCFS Workers

Youth described the negative or unhelpful interactions experienced with DCFS workers in 21 instances. These interactions included:

- Failure of DCFS worker to provide information or guidance in accessing resources such as transitional services, housing, and education support (8 instances),
- Negative interactions with the caseworker in general/ did not trust them (6 instances), and
- Safety issues were not properly investigated by social worker when youth reported the concern, or a general lack of oversight of the placement (5 instances).

Youth also described the positive or helpful interaction they experienced with DCFS worker in 8 instances. These interactions included:

- Assistance in accessing needed transitional, education, and/or housing resources (5 instances) and
- Emotional support and mentorship (3 instances).

Interactions with Group Home Workers

Youth also described their negative and positive experiences with group home workers. These interactions included:

- Group home workers being uncaring and overly authoritarian (4 instances),
- Positive experiences with group home workers being caring and supportive (3 instances), and
- Group home workers not properly monitoring youth in care or not following-up on complaints (2 instances).

"They are like are mothers, and whoever our transitional coordinators are, our case managers are, they are really like a mom to us. Coming to check our place and just being there for us all the way around."

System Responses

Transitional aged youth identified occasions when the system's response to their needs was helpful (18 instances) and when the response was unhelpful (18 instances). Common themes among the positive and negative system responses are outlined below.

Positive System Responses:

- Independent Living Program (ILP) – youth reported that ILP services allowed them a helping hand in trying to become an independent adult after aging out (7 instances),
- Education assistance – youth reported that assistance with college applications, scholarships, and internships helped them obtain a higher education after aging out (5 instances),
- Housing assistance – youth reported that housing assistance helped them have a stable and safe home (4 instances), and
- Wraparound services – youth reported that wraparound services and wraparound coordinators were helpful in securing the resources they needed (2 instances).

> **"I like how they [Independent Living Program] give you kind of like a second chance. If you don't learn how to grow and live they teach you. They help you a lot."**

Negative System Responses

- Multiple placements – youth discussed the negative effects of being moved numerous times while in care, including difficulties adjusting, forming attachments, and feeling safe (6 instances),
- Unnatural and uncaring home settings – youth discussed the negative effects of being placed in foster homes and group homes with caregivers who were not loving and caring, making them feel like they were not in a real home (4 instances), and
- Unhelpful therapist and use of medications – youth discussed having multiple therapists/ Psychiatrists who pressured youth to talk about the past and can be too quick to medicate (2 instances).

Community Responses

Youth reported receiving meaningful help from the greater community, outside of the formal system (10 instances). These responses included:

- Educators and other school personnel – youth reported that school teachers and counselors from elementary school through college were helpful in providing support and mentorship (5 instances), and
- Faith leaders – youth reported that community faith leaders and pastors offered emotional support and guidance that helped them to succeed (3 instances).

Transitional Aged Youth Recommendations

The following recommendations were mentioned explicitly by youth during focus groups as ways to improve their experience and how the system interacts with them,

Improving Caseworker Interactions

1. Throughout the focus group and interviews youth discussed the mistrust of DCFS workers to respond to their safety needs and to remove them from an unsafe foster home or group home. Youth often felt that workers would not believe them, would label

them as difficult to place, or simply ignore them if they reported safety issues. DCFS should offer staff training on responding to foster youth's safety concerns in out-of-home care and enact policies that ensure all safety concerns are responded to in a timely and appropriate manner.

2. Youth reported that DCFS workers often could not relate to their experiences as foster youth and lacked empathy. The youth recommended that DCFS hire more workers that are foster care alumni. DCFS should consider employing foster care alumni within DCFS offices as caseworkers and/or youth advocates to ensure foster youth feel comfortable discussing safety concerns with DCFS and to ensure DCFS is responding in a youth appropriate manor.

3. Youth also discussed DCFS workers lack of follow-through and assistance in accessing resources. Youth believed that high caseloads are a major factor and recommend that DCFS workers have smaller caseloads that are specialized for older foster youth to ensure they receive the assistance needed in transitioning to adulthood.

4. Youth reported that they lack an easily accessible process to file a complaint about a DCFS worker. DCFS should establish a centralized grievance system that is easily identifiable and accessible by youth and provides a timely response to all youth complaints.

Improving Access to Quality Foster Homes and Group Homes

5. Youth reported a critical lack of access to quality foster homes where parents truly cared about the emotional and/or physical well-being of the children in their home. Youth recommended that DCFS increase their foster home recruitment, improve the screening process to ensure that foster parent truly care about children and youth, increase the amount of required training and include older youth specific training, and increase the amount of unannounced drop-in visits per month.

6. Youth also reported a lack of choice in where they were placed and recommended that DCFS require youth input in placement changes. The youth recommended creating a system where a youth could interview a potential foster home or group home before placement. They also recommended that youth have an exit interview when changing placements to gather information on their experiences in order to better inform DCFS on the quality of the placement.

7. Youth reported that group home workers often lacked boundaries and professionalism causing safety risks to youth in the home. Youth recommended DCFS improve the screening of group home workers and that DCFS regulate and monitor group home more often and without announcement to the group home.

8. Youth reported that group homes were often over structured and over scheduled with too many rules and not enough choices. Youth report that this does not prepare them for life as an adult and recommended that DCFS work with group homes to create a more natural home environment that better prepares youth with the life skills required for successful adulthood.

Access to Transitional Services

9. Youth discussed the great benefit of the Independent Living Program (ILP) in providing assistance with housing, education, and employment. However many youth reported that they felt unprepared for adulthood and struggled with finding housing, securing employment, and continuing their education because they were unaware of transitional services and how to access them. DCFS should ensure that every youth in care at the age of 14 develop a transition plan that outlines goals and objectives of transitioning to adulthood and re-visit the plan every 6 months to ensure the youth has full access to all the transition resources needed.

Additional Support for Transitional Aged Youth

10. Youth identified the need for more time to socialize and network with other foster youth. They discussed the power of connecting with youth who have lived similar experiences for emotional support. DCFS should offer more opportunities and space for peer support for foster youth and foster alumni.

Themes from LGBTQ Foster Youth

The following themes were developed from qualitative analysis of documentation from the two focus groups that the BRC team conducted with LGBTQ youth living in LA County, who have experienced foster care.

Self-identified safety issues

Safety needs were discussed throughout the focus groups and interviews conducted with LGBTQ foster youth (34 instances). These safety concerns are broken into issues reported in foster homes, group homes, bio-parent homes, and those directly related to identifying as LGBTQ and to being homeless.

> **"I was like a loner to the other boys because me coming out as being gay and all that, I would get picked on; I would have to fight in the group home. So I would always be by myself"**
> **---Transgendered female**

Safety Issues in Foster Homes

- Neglect – youth reported that they were not provided with the proper food, clothing, educational assistance, or emotional support (5 instances),
- Physical abuse – youth reported being hit or beaten by foster parents or others in the foster home (4 instances), and
- Sexual assault – youth reported being sexually assaulted in foster homes (2 instances).

Safety Issues in Group Homes

- Bullying, harassment, and/or physical assaults perpetrated by other youth living in the group home often based on sexual orientation (3 instances) and
- Neglectful or abusive behavior perpetrated by group home staff (2 instances).

> **"Once I told them I was gay and I liked dressing up in girls' clothes and doing all these feminine things, they made me go to counseling session and stuff, rehab and all that crap. They even put me in a Christian camp, like a Christian group home camp…. I felt like I was trying to be gay exorcised, like an exorcism"**
> **---Transgendered female**

Safety Issues in Birth-Parent Home

- Emotional abuse (3 instances), physical abuse (1 instance), and neglect (1 instance).
- Substance abusing caregiver (2 instances).

Safety Issues Related to Identifying as LGBTQ

- Having to hide your identity for fear of safety – youth discussed having to compromise emotional well-being by hiding their identity (5 instances) and
- Community harassment and abuse –youth discussed verbal and physical harassment on the streets, in schools, and in community services (4 instances).

Safety Issues Related to Homelessness

All of the youth who attended the focus groups had experienced homelessness and identified the following needs related to their experiences with homelessness:

- Access to health care, food, and other basic needs (5 instances) and
- Lack of affordable and safe housing (4 instances).

> **"That [hiding your identity] puts a lot of pressure on young people too. If they are in the closet and they have to meet to the standards of whatever home or group home they are in; it's not healthy at all. If that's who they want to be down the long road and they keep holding it in and not letting nobody know it is dangerous."**
> **---Transgendered female**

Interactions with Professionals

LGBTQ foster youth described mostly negative experiences with professionals within the child welfare system (DCFS workers, group home workers, and private agencies), reporting 13 instances of negative interactions and 1 instance of a positive interaction. These interactions included:

- Non-responsive workers –youth reported that caseworkers and group home staff often did not believe youth when reporting safety concerns and did not properly address the concern (3 instances). They were also unresponsive to general needs requests (4 instances) and
- Insensitive workers –youth reported that professionals throughout the system lacked sensitivity to both the general needs of youth and to the unique needs of LGBTQ youth (4 instances).

System Responses

Unhelpful System Response

LGBTQ foster youth identified times when the system's response to their needs was unhelpful (6 instances) Common themes among the negative system responses are outlined below:

- Lack of control or input on case decisions – youth described having little to no input on services or case decisions such as placements, family visits, or schooling (4 instances) and

- Services aimed at trying to change sexual orientation or gender identity – two youth reported that they were sent to faith-based services that attempted to change their LGBTQ identity (2 instances).

Helpful System Response
LGBTQ foster youth also identified times when the system's response to their needs was helpful (2 instances):

- Therapeutic services that were affirming and helpful (1instance) and
- Housing services that helped youth avoid homelessness (1 instance).

Community Responses

Both focus groups were conducted at the LA Gay and Lesbian Center and youth identified helpful community responses that are provided by the center, which include:

- Knowledge and provision of LGBTQ-friendly services – youth described comprehensive resources that were provided by the center (health care, counseling, housing, and employment) and the knowledgeable staff who could refer youth to other LGBTQ friendly services in the community (6 instances) and
- A welcoming and affirming community space – youth also described the LGBTQ-friendly space that the center provided for social/emotional support and for physical safety (6 instances).

LGBTQ Foster Youth Recommendations

The following recommendations were mentioned explicitly by youth during focus groups as ways to improve their experience and how the system interacts with them. In addition, recommendations emerged through the analysis of focus group themes, and recommendations from the Hollywood Homeless Youth Partnership Report, which directly spoke to the intersection of child welfare and homelessness in LA County.

Improving Worker Interactions

1. LGBTQ youth discussed the mistrust of child welfare workers to respond to their safety needs and to remove them from an unsafe foster home or group home. Youth often felt that workers would not believe them and instead label them as difficult; at times youth believed this to be directly related to their LGBTQ identity. DCFS should offer staff training on responding to LGBTQ foster youth's safety concerns in out-of-home care and enact policies that ensure all safety concerns are responded to in a timely and appropriate manner.

2. Youth reported that child welfare workers often could not relate to their experiences as foster youth, particularly as LGBTQ youth, and lacked empathy. The youth recommended that both CPS and group homes hire more workers that are LGBTQ foster care alumni. LA County should consider employing LGBTQ foster care alumni within DCFS offices as caseworkers and/or youth advocates to ensure foster youth feel comfortable discussing safety concerns with DCFS and to ensure DCFS is responding in a LGBTQ youth appropriate manner.

3. At times, LGBTQ youth reported not only a lack of empathy within the child welfare systems but outright discrimination and harassment by child welfare professionals. LA

County should require system-wide training of public child welfare workers and private providers on LGBTQ issues as they relate to children and youth in care and should turn to national leaders such as the Los Angeles Gay and Lesbian Center for best practices in trainings.

4. LGBTQ youth also reported that they do not have an easily accessible process to file a complaint about public child welfare workers or group home workers when they feel they are being discriminated against or they are not receiving the services they need. DCFS should establish a centralized grievance system that is easily identifiable and accessible by youth and provides a timely response to all youth complaints.

Improving Physical and Emotional Safety for LGBTQ Foster Youth

5. Youth reported high instances of abuse and neglect in foster homes and group homes by both caregivers and fellow foster youth, which is consistent with national literature on the experiences of LGBTQ foster youth. Youth recommended that the child welfare system increase their recruitment efforts around LGBTQ sensitive foster caregivers, improve the screening process for foster homes and group homes to ensure that a placement is LGBTQ affirming, and improve the training given to caregivers on LGBTQ issues.

6. LGBTQ Youth also reported a lack of choice in where they were placed and recommended that child welfare workers be required to obtain youth input in placement decisions and changes. The youth recommended creating a system where a youth could interview a potential foster home or group home before placement, specifically to assess if the placement was an LGBTQ affirming placement and safe for an LGBTQ youth. They also recommended that youth have an exit interview when changing placements to gather information on their experiences in order to better inform the County on the quality of the placement.

7. LGBTQ youth reported that they often do not know where it is safe to openly share their identity, which causes them to feel the need to hide who they are. The youth recommended that child welfare offices and all county services use GLBT Safe Place stickers or other LGBTQ symbols to indicate that both the space and the services are safe and affirming for LGBTQ youth.

"There is not a lot of places like the Gay and Lesbian Center where youth can come and shower, and watch TV, and sleep, and eat, and get clothes. And have someone to talk to. It shouldn't be about gender, it shouldn't be about race, it shouldn't be about sexuality, it shouldn't be about nothing, we are all human beings, and we all have emotions. And love is love. And when I come to the Center, I always get love from everyone, staff and clients."
---Gay female

Preventing LGBTQ Foster Youth from Becoming Homeless
The safety issues that LGBTQ foster youth face across the country lead to a disproportionate amount of LGBTQ foster youth within the national homeless population and LA County is no exception. A 2011 study of homeless youth in Hollywood found that 45% of homeless youth identified as LGBTQ and 48% of homeless youth reported involvement with Child Protective Services at some point in their lives, with 40% reporting an out-of-home placement (Hollywood Homeless Youth Partnership, 2011). The Hollywood Homeless Youth Partnership spoke with close to 400 homeless youth residing in Hollywood and developed the following recommendations, many of which were echoed by the youth spoken to for this report:[1]

1. "Expand funding for the Chaffee Foster Care Independence Program (CFCIP) to provide housing and supportive services to youth emancipating from foster care and former foster youth."

2. "Prohibit the release of youth from public systems or institutional care unless there are documented, feasible plans for placement in appropriate, stable, and supportive housing services or family homes, and increase resources so that agency staff can monitor placement suitability and stability after release."

3. "Reduce the number of out-of-home placements for youth under the jurisdiction of Child Protective Services (CPS) and/or Probation and reduce the number of times youth are transferred to new case workers when placements are changed or youth are moved from one secure environment to another."

4. "Require that the child welfare system implement cross-county and inter-state funding mechanisms for housing and supportive services for youth, including Independent Living Program (ILP) services, to ensure that youth can access benefits when they have left or been released from care in other communities."

5. "Require that all public service systems screen youth for homelessness and facilitate access and linkage to housing, public benefits, medical and behavioral health care, education and job training programs, and other supportive services, as needed."

Themes from Birth Parents

The following themes were developed from qualitative analysis of documentation from focus groups and interviews that the BRC team conducted with birth parents in Los Angeles County. Most of the birth parents had an open DCFS case at the time of the focus group or interview, but many of them had already been reunified with their children and were working towards case closure.

Self-Identified Safety Issues
Birth parents identified a variety of safety concerns, some in their own home, some in foster homes, and some in the community. Safety issues that arose in foster care were concerns that

[1] Hollywood Homeless Youth Partnership. (2011). *No Way Home: Understanding the needs and experiences of homeless youth in Hollywood.* Hollywood, CA. Page 61. Retrieved from: http://hhyp.org/downloads/HHYP_TCE_Report_11-17-10.pdf

were either observed by the birth parent directly or were reported by the child to the parent.

Safety Issues in Birth Parent Home

- Child's mental health or developmental delays (5 instances),
- Domestic violence by a partner (4 instances), and
- Substance abuse (2 instances).

> **"If they would have given me the option to go into rehab I would have – but they took my son first."**

Safety Issues in Foster Care

- Physical abuse, emotional neglect, physical neglect (4 instances),
- Lack of supervision (2 instances),
- Running away (2 instances), and
- Inability to enforce medication management (1 instance).

Safety Issues in the Community

- Gang activities, drug use, and neighborhood violence (3 instances)

> **"There is always a way to prevent tearing families apart."**

System-Identified Safety Issues

In addition to the above safety concerns, birth parents also reported safety allegations that were made against them, but that they denied.

- Domestic violence (1 instance),
- Physical abuse (1 instance), and
- Parent's mental and physical health (1 instance).

Prevention of Safety Issues

Strategies to increase safety were discussed by birth parents in two ways: one, system responses to prevent the removal of their children while still ensuring their safety; and two, individual responses to address community safety concerns.

Prevention of Child Removal

- Inpatient substance abuse treatment with their children (1 instance),
- Opportunity to engage in services prior to placement (1 instance), and
- Opportunity to place with relatives while incarcerated (1 instance).

Increasing Community Safety

- Banning gang members, drug users, unsafe family members, and even explicit popular culture/media influences from the home (2 instances) and
- Building relationships between neighbors (1 instance).

Worker Interactions

While the majority of feedback from birth parents regarding their caseworkers was negative, some parents did have positive

> **"My social worker goes above and beyond for me, I can call her anytime and ask for advice, she tries to always be there for me – but she is really busy because they all have so many cases…I want to stress that they need to lighten cases for the social workers."**

experiences with their caseworker. A few parents also noted that caseload sizes were a significant barrier, as caseworkers simply did not have the time needed to work effectively with each family (4 instances).

Positive Caseworker Experiences

- Caseworkers connecting parents to services and concrete needs. One even helped a parent obtain employment and another gave a parent a gift to give to his son on Father's Day (8 instances),
- DCFS caseworkers working well with Parents in Partnership, particularly with fathers and with undocumented parents (2 instances), and
- Being available to simply listen and provide support, even if the caseworker was not able to give the parent what they wanted (2 instances).

Negative Caseworker Experiences

- Having a judgmental, disrespectful, and authoritative attitude towards parents, and not respecting confidentiality (13 instances),
- Focusing only on the children and not trying to help parents so that they can avoid removals or reunify (8 instances),
- Not informing parents about available services or helping them to access services (5 instances),
- Not listening to parents' concerns regarding foster parents (2 instance),
- Lack of communication between caseworkers in different counties (1 instance), and
- Traumatizing children during investigations (1 instance).

"Even though they took the children from me, it doesn't mean that I'm out of their life. The [foster parent] made it sound like we were criminals because they took our children from us."

System Responses/Services

Overall, birth parents did have positive feedback regarding services and other system responses; however, many also had negative experiences. A common theme among birth parents was that they simply did not know about services or could not access them.

Helpful System Response/Services

- Parenting classes, mental health, substance abuse, and domestic violence services (14 instances),
- Concrete resources such as housing assistance, transportation, furniture, food, etc. (8 instances),
- Services for children (5 instances),
- Shields, Parents in Partnership, and Bienvenidos are particularly helpful (5 instances), and
- Spanish-speaking services were generally considered good (3 instances).

Unhelpful System Response/Services

- Not providing any information or referrals to services (19 instances),
- Treating parents like criminals and in a very punitive manner (6 instances),

"The first social worker that came out and took my son away from me, she told me that she could have given me a referral to go see a therapist before he was taken away, but she told me that after the fact when she came to take him away from me – I wasn't given that opportunity to do services before he was taken away."

- Financial or housing services were either not available or take too long (4 instances),
- Not considering the child's needs/preferences during the investigation and placement (3 instances),
- Providing services that do not consider parents' needs, i.e., late bus passes (2 instances) or work schedules (1 instance),
- Offering services after the child has already been removed, instead of providing prevention services (2 instances),
- Ordering services for children that were not age-appropriate (2 instances),
- Group care that was ineffective at meeting children's mental health needs (2 instances),
- Not providing reunification services (1 instance), and
- Providing outdated information regarding services (1 instance).

Recommendations of Birth Parents

The following recommendations were either mentioned explicitly by birth parents during focus groups and interviews as ways to improve their experience and how the system interacts with them, or the recommendations emerged from focus group and interview themes, as primary issues that deserve greater attention from the County.

Improving System Response and Caseworker Interactions

1. The most prevalent recommendation across the focus groups and interviews was that caseworkers need to treat parents with respect, honesty, and compassion instead of blaming them or making assumptions about them based upon their appearance. Caseworker training should include a strengths-based, family-centered focus that helps caseworkers develop the skills needed to effectively engage families and support their efforts towards reunification.

2. Efforts to prevent an out-of-home placement should always be exhausted prior to removing children from their parents.

3. Caseloads need to be smaller, so that caseworkers can work with parents to either try to prevent removal of their children or to try to reunify them. Current caseload sizes do not allow caseworkers to communicate effectively or spend sufficient time with families in the way that is needed in order to keep families together.

4. Investigations need to be conducted in a way that is more sensitive to children, for example, even superficial physical examinations should be done by an investigator of the same gender and preferably in a neutral/safe space.

Improving Foster Care Safety

5. Screening foster parents should be a rigorous process, in order to ensure that foster homes are both safe and nurturing. Birth parents should have an avenue for reporting concerns to a neutral third party, such as an ombudsman's office or a confidential hotline. Birth parents should be informed that such a resource exists and how to access it.

Access to Services

6. Families need to be supported through the process of engaging in services, rather than simply told what they need to do. Caseworkers should provide families with information regarding what services and resources are available, as well as how to access them.

7. Parents with open cases should have priority for low-income housing, so that they can reunify with their children more quickly.

Themes from Kinship Caregivers

The following themes were developed from qualitative analysis of documentation from focus groups and interviews that the BRC team conducted with kinship caregivers in Los Angeles County.

> **"Some of the [foster] homes, they are already overwhelmed, they are meeting their concrete needs but are they really meeting what the children need? I make sure my grandchildren have everything."**

Self-Identified Needs

Kinship caregiver participants identified some of their needs in raising the children in their care. These needs can be broken down into the following categories:

- Financial support or additional levels of financial support (15 instances). In one instance, a participant believed that additional financial support will benefit the County in the long-run by preventing the need for foster care, and ending the cycle of system involvement,
- Accessing or maintaining health or mental health services (10 instances). Many caregivers noted that their kin often have developmental issues due to drug exposure, and as a result, their increased vulnerability requires much more care than typical children,
- Subsidized childcare (8 instances). This was a major issue for kinship caregivers who need to work to provide for their family. A few caregivers mentioned that they lost their job, or had to give up their jobs because they needed to care for their kin, and
- Dealing with a range of child behavior issues in which they needed support, including aggression, school delinquency, suicidal ideation and attempts, and other out of control behaviors (3 instances).

Safety Issues in Foster Care

Caregivers expressed concerns and fears about their kin in foster care, which was the reason that several caregivers gave for taking custody of the child. They expressed these concerns either as fears about what the child would experience in foster care, or through direct experiences that were negative. The following concerns were shared by caregivers as to why they wanted to keep their kin out of foster care:

- Foster care not meeting their children's needs (2 instances),
- Previous abuse in the system (2 instances),
- Foster parents are only in it for financial gain, because they are not family (2 instances),
- Foster homes/ group homes need more County oversight (2 instances),
- Fears about loss of contact with the child if they enter foster care (1 instance), and
- Instability or multiple placements (1 instance).

Helpful System Response or Services

The largest source of support for kinship caregivers was from kinship advocacy groups such as Grandparents as Parents (GAP) and Raising Our Children's Kids (ROCK), which provide support groups, system navigation services, and family advocacy. Participants also mentioned that they received support from other community-based organizations, DCFS, Courts, other County agencies, and school districts. A few participants also remarked that the kinship division of the DCFS was supposed to be the advocate for grandparents and grandparents' rights, but because they have not filled that role, caregivers have sought out support from other sources. One participant shared that many caregivers do not know about GAP and ROCK, and are therefore left to fend for themselves. Focus group participants described the more helpful sources of support that helped them to better take care of the children in their care:

- Kinship advocacy groups such as GAP and ROCK (11 instances),
- Other community-based organizations (8 instances),
- Services and supports provided by DCFS (6 instances),
- Courts (3 instances),
- Services and supports provided by other County agencies (2 instances), and
- School districts (2 instances).

"DCFS often prevents caregivers from knowing about kinship organizations like GAP and they do not embrace the help and services that these organizations provide. In some cases, caregivers will be told that if they participate or contact GAP that they will be denied benefits."

Unhelpful System Response or Services

By far, the largest theme from Kinship caregiver participants was that they received system responses that were not helpful in supporting them to take care of their kin. Unhelpful system responses were mentioned a total of 107 times, far surpassing helpful system responses (mentioned 33 times). Note also that among helpful system responses, most of those were not provided by the County. Caseworker interactions, which are a subtheme of helpful/ unhelpful system responses, are broken down in greater detail in the following section. Given that caregivers discussed negative experiences with county agencies and private providers at a rate far higher than positive experiences, we can conclude that service systems in LA County are not interacting well with kinship caregivers. Their feedback fits into the following categories:

- Caseworker[2] did not provide enough communication, listen well, or follow-through (21 instances),
- Caseworker showed disrespect, threatened retribution or the denial of services, or abused power in general (17 instances),

"GAP is the functioning ombudsman that DCFS doesn't have but should have. DCFS should have an ombudsman in each office that serves the role that GAP does in the community. This would include someone objective who could look at the data without taking sides and analyze the situation without simply relying on the social worker's story."

[2] Note that caregivers typically did not specify which agencies workers belonged to. While it is likely that the large majority of the workers that caregivers referred to were from DCFS, other agencies were referred to as well.

- Caretaker received a lack of help in navigating a complex system to access services (14 instances),
- Services/ supports were not provided to help caregivers (13 instances),
- DCFS took harsh or unnecessarily invasive actions, often leading to loss of contact with child (13 instances),
- Caseworker provided falsified information to the caregiver, or submitted false reports (9 instances),
- DCFS did not take allegations from the kinship caregiver seriously enough (5 instances),
- DCFS pressured the caregiver to adopt children, which would result in service ineligibility (4 instances),
- Caregiver was just seeking help, then became trapped in the system (3 instances), and
- Caregiver chose not seek help from DCFS due to fear of retribution (1 instance).

"DCFS treats kinship caregivers as "uneducated babysitters" who do not need any financial help because they are related to the children. While kinship caregivers sacrifice themselves to support the children, DCFS does not appreciate our efforts. DCFS social workers need to show more compassion."

Caseworker Interactions

Kinship focus group participants described particularly negative interactions with caseworkers from several County agencies. Among all of the interactions between caregivers and caseworkers that were identified in focus group notes, positive interactions were mentioned 4 times, and negative interactions were mentioned a total of 62 times. Caregivers describe particularly adversarial, harsh, and generally unhelpful interactions with caseworkers, reflecting a systemic lack of regard for kinship caregivers' role in providing for the needs of children in the County.

Rights to the Child/ Legal Barriers

Participants identified legal barriers in exercising their role as primary caregivers. Participants shared that their rights were frequently overridden by birth parents and foster parents, whom they often perceived to not be acting in the best interests of the child. Categories for legal barriers identified by caregivers include:

- Kinship Caregivers have limited legal rights to the child or the court did not adequately recognize their rights (17 instances), and
- Caregivers need help in advocating their legal rights or expressed difficulty in accessing legal services (5 instances).

"DCFS threatened me that I had to adopt my grandchildren or they would take the children away from me and give them to someone who would adopt them. Alliance for Children's Rights helped me fight for full custody but without adoption."

Spanish-Language Assistance

Spanish-speaking caregivers shared that County services and court proceedings did not adequately provide them with information in Spanish, limiting their ability to participate in the process and meet their children's needs. Specific difficulties mentioned regarding Spanish-language assistance include:

- Caseworkers need to better explain to caregivers about the system and proceedings in Spanish (3 instances),
- Appearing in court without a translator, or a need better quality translators (2 instances), and
- Agency paperwork was provided only in English (1 instance).

"No one has bothered to explain the adoption process. We've slowly learned along the way, but it seems no one knows the full process because they always tell us go talk to "so and so" and go talk to "so and so." Thank goodness we know a little English."

Kinship Caregiver Recommendations

The following recommendations were either mentioned explicitly by kinship caregivers during focus groups as ways to improve their experience and how the system interacts with them, or the recommendations emerged from focus group themes, as primary issues that deserve greater attention from the County.

Improving System Response and Caseworker Interactions

1. Initiate staff development efforts focused on demonstrating respect for clients and working with them in helpful, collaborative ways. These efforts should include changes to staff hiring, training, and supervision/ coaching processes. Developing better relationships with kinship caregivers is especially important, as they are the most frequent placement option for children in the County.[3] Additional emphasis should be placed on recognizing kinship caregivers' role and their legal rights to the child.

2. DCFS should place more priority on meeting the specific needs of kinship caregivers to better provide for their kin. Recruitment efforts ought to include seeking out experience in working with kinship caregivers, and those who can relate well with kinship caregivers.

3. Due to the sheer number of complaints regarding County caseworkers related to disrespect, misusing power, and filing inaccurate reports, the County should hire an ombudsman for each local office, and/or expand the existing ombudsman's office capacity to better address client complaints.

4. Enforce current policy of prioritizing kinship placements over non-relative placements, and allow children to have more say in their placement options.

Access to Services

5. Provide access to quality mental health services and substance abuse treatment for child and caregiver, and provide such services earlier on to prevent initial foster care placement.

6. Provide enhanced Spanish-translation services, including additional translators available for court, and provide a simple process for requesting translations of agency documents

[3] California Child Welfare Indicators Project, data retrieved 1/8/14 from: http://cssr.berkeley.edu/ucb_childwelfare/pit.aspx

and case reports.

Additional Support for Kinship Caregivers

7. Provide additional levels of financial support for kinship caregivers, and allow for greater flexibility in how funds are used to provide services. As one participant discussed, additional financial support may benefit the County in the long-run by preventing the need for foster care, and ending the cycle of system-involvement.

8. The County should actively support and navigate parents towards kinship organizations such as GAP and ROCK, and never threaten caregivers to avoid them.

9. Provide additional navigation support specifically targeting kinship caregivers, to help them to navigate a complex system in order to access services to better meet their children's needs.

10. The County's system of services and supports is fragmented and difficult to navigate. As a result, the County should create a centralized resource or community services guide, tailored to the needs of kinship caregivers (among other populations), that describes all of the services and supports available in each SPA. Such a guide should include contact persons, and be regularly updated. Web-based and paper versions of such a guide would be a way of reaching a larger audience (including kinship caregivers, additional client populations, caseworkers, and community providers) that is actively looking for this information.

11. Provide kinship caregivers with better access to legal services, including an expanded array of legal services that can be monitored for quality.

Themes from Foster and Adoptive Parents

The following themes were developed from qualitative analysis of documentation from the focus groups and individual interviews that the BRC team conducted with foster and adoptive parents in Los Angeles County.

Worker Interactions

All of the foster and adoptive parent participants reported negative experiences with the caseworkers assigned to their case, mainly involving a lack of communication on the part of the caseworker. Some additional comments around negative caseworker interactions included the following:

Negative Caseworkers Interactions

- There was a lack of communication and follow-through by caseworkers about how to obtain services (6 instances),
- Foster and adoptive parents did not feel respected by the caseworkers and as a result, there was a sense of

"Social workers, nothing against them, but they are not supportive of us. They never return our phone calls. We have to do everything for ourselves. I just can't understand that."

mistrust of the agency (3 instances),
- Foster parents highlighted that they were left out of important decisions concerning the child, even though they were the ones providing the daily care (3 instances), and
- Caseworkers did not return phone calls in a timely manner, if at all. At times foster parents did not know who the current caseworker was or who to call (2 instances).

In addition, foster and adoptive parents expressed frustration with frequent caseworker turnovers and its disruptive impact on the child (4 instances). Many foster parents had multiple caseworkers during the life of the case and this made it difficult to build a trusting relationship with them (3 instances). One commented that they "have to start over again" every time they have a new worker.

"For us, it has not been challenging to love and care for him. What has been difficult has simply been getting the services he needs…. It's getting through the system to get to the services that we all know he needs but are so difficult to put in place. Once they are there though, they are great."

System Responses/Services

The most common theme across the focus groups and interviews was that foster and adoptive parents felt frustrated when trying to access services for the child in their care.

Unhelpful System Responses/Services

- Many claimed that they did not know who to contact to find out which services were available to them and how to obtain them (6 instances),
- The challenges of trying to navigate through a complex and overwhelming bureaucracy, with foster parents often giving up on trying to find much needed services (3 instances), and
- Older youth need more high-quality mental and behavioral health services, as well as better transition services (2 instances).

Helpful System Responses/Services

Foster and adoptive parents were pleased with the services that they received once they were in place. Some of the services identified as helpful include:

- Individual counseling (4 instances),
- Family therapy (3 instances),
- Wraparound services (1 instance), and
- Educational advocacy (1 instance).

"One of the things I would improve upon is the time it takes to get a child. Everyone always talked about how many kids were in foster care and that they needed Spanish speaking foster homes, but it took us almost three years to get our first foster child."

Systemic Barriers to Placement and Permanency

Foster and adoptive parent focus group participants highlighted the challenges of trying to learn about the different permanency options available to them. They also claimed there were significant delays in placement of children and adoption finalization. For example, one foster parent waited three years to have a child placed in their home while another adoptive parent shared with the group that it took four years to adopt their child.

Uninformed about Permanency Options

- No one available to explain and inform them about their permanency options, and it was confusing to try and figure out on their own (3 instances).

Foster Care Placement and Adoption Delays

- Foster and adoptive parents also reported that it took a significant amount of time to have a child placed in their care and for the adoption to be finalized (3 instances),
- Delay in getting home study completed (1 instance), and
- Adoption process was more difficult for non-native English speakers (1 instance).

Foster and Adoptive Parent Recommendations

The following recommendations were either mentioned explicitly by foster and adoptive parents during the focus groups and interviews as ways to improve their experience and how the system interacts with them, or the recommendations emerged from the above themes as primary issues that deserve greater attention from the County.

Improving Caseworker Interactions and System Response

1. Foster and adoptive parents emphasized that a cultural shift among DCFS workers is necessary so that they treat foster/adoptive parents and children with the respect that they deserve.

2. Caseworkers need to have consistent communication with foster and adoptive parents about their case and also provide the support needed to navigate a complex system in order to obtain appropriate services for the children in their care.

3. There should be a neutral and formal advisory group that allows foster parents the opportunity to voice their concerns about the child welfare system. There should also be more foster parent support groups so that they can learn about the services that are available to them and the children in their care, and to connect to other foster parents sharing a common experience.

Improving Barriers to Placement and Permanency

4. Foster parents recommended that DCFS shorten the amount of time it takes for a child to be placed in their care by improving placement processes, such as hiring more home visit workers. Adoptive parents also recommended that the time to finalizing adoptions should be significantly shortened.

5. Both foster and adoptive parents reported that LA County workers did not explain the different permanency options to them, which led to confusion and frustration. They advised that DCFS should train caseworkers in how to better explore permanency options with potential adoptive parents.

6. Foster parents in particular requested that DCFS provide more background information on the children that are placed with them, specifically around medical and behavioral issues and education background.

Access to Services

7. Foster and adoptive parents recommended improving access to quality mental health services for youth and also to provide transitional housing services for youth once they age-out of the system.

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APPENDIX 3

Report of the Organizational Structure, Measurement, and Accountability Subcommittee

Presented by Commissioner Andrea Rich to the

Blue Ribbon Commission on Child Protection

March 28, 2014

This Los Angeles County Blue Ribbon Commission on Child Protection is but the most recent of many such investigatory bodies appointed to analyze and offer recommendations to improve the County's Child Welfare System. We find that, despite extensive previous efforts at reform, the current system remains fundamentally flawed and does not fulfill its mission to protect and nurture the children of the County. The Commission is further convinced that, without a total transformation of its current mission, philosophy and organizational structure, the County's future efforts at reform will continue to fail. We wish to emphasize that we believe no particular County office uniquely is to blame. The fault rests in a lack of strategic leadership and the nature of bureaucratic responses to problems and crises, responses ultimately creating a web of inconsistent policies and practices leading to unintended tragic consequences.

I. THE TWO MAJOR IMPEDIMENTS TO REFORM

A. Bureaucratic Constraints

In the absence of a clear vision and strong leadership, bureaucracies often emerge as the default method of solving complex problems and delivering services to large numbers of people. Bureaucracies tend to be reactive, solving one problem at a time, seriatim, over time, creating administrative structures, starting programs, and allocating resources with no overall perspective. As these reactive solutions multiply, initial problems become obscured and workable solutions difficult, if not impossible, to identify within the resulting bureaucratic maze.

Bureaucracies, not carefully managed and consistently improved, have characteristics that are destructive to client-oriented services, impede innovation, and stifle efforts at self-improvement. The top-down authority, narrow span of control, and risk aversion typical of bureaucratic processes constantly thwart efforts toward meaningful reform.

As a result, County departments dealing with children often become silos, protective of their own turf, philosophical approach, and resources. During its deliberations, the Commission did find some excellent examples in which departments worked together. Such examples, unfortunately, seemed the exception rather than the rule. For the most part, the departments seldom seemed to work together effectively to solve joint problems on their own initiative; rather, such efforts appear driven by negative media attention, public complaint, and recommendations from outside consultants and/or by order of the Board of Supervisors.

Because of these discreet bureaucratic silos within which the welfare of children resides, the County of Los Angeles has developed no over all mission with regard to the welfare of children. It has never developed a countywide strategic plan that leverages all County resources toward the implementation of interconnected goals for all the departments in the County with responsibilities regarding children. The County, therefore, has no ability to leverage the huge investment of resources it has made toward the maximization of its child welfare mission. Too often, it has forfeited its ability to gain benefit from the sum of its parts.

B. Legal Constraints

In attempting to fulfill our assigned duties to investigate the impediments to reform, the Commission ran into a major roadblock to the achievement of its own mission. In trying to determine the causes of some of the tragic incidents of child deaths within the County system, we requested access to critically relevant reports to enable us to trace any pattern of flaws in the child welfare process that would help us offer recommendations for improvement. Much to our surprise, County Counsel denied our requests, claiming the Board of Supervisor's "fiduciary responsibility" and "client confidentiality" prohibited our viewing these materials. We continued to be surprised when we discovered the "client" was not the children and families under study, but the County itself.

The difficulty the Commission experienced in obtaining access to these relevant reports demonstrated to us how County Counsel's legal predispositions and restrictive attitudes impede reform efforts. If the very body appointed to investigate these tragedies found it impossible to obtain the relevant existing data analyzing these incidents, how could we be expected to offer the most informed recommendations? How could we determine if the recommendations in these reports had been fully adopted or successful in informing current practices?

This restrictive legal attitude has had a chilling affect when applied to efforts by departments toward self- improvement and innovation. When a health hub initially tried to remain open seven days per week, twenty-four hours a day, its leader was told by the County's attorneys it could not be done. A persistent service provider found a way anyway. When a communication system between two departments first was being developed to reduce social worker input time and increase accuracy of medical information on children, a federal/state bureaucratic policy was found to stall the development. There appears to be a pervasive fear throughout the County of potential lawsuits and active pursuit of policy changes that might result from improvements designed to correct discovered deficiencies, since such discoveries could be interpreted as an admission of wrongdoing. The official legal position of County Counsel seems to reflect an unquestioning acceptance of all existing statutes and policies and an avoidance of any attempt at change, for fear that such a change might lead to a conflict or lawsuit.

It is completely reasonable and appropriate that the County's legal advisory structure should aim to keep County practices on the right side of the law. Programs involving child welfare, however, present a particular challenge in this regard. Social welfare policies and legislation enacted by governments at all levels, though well intentioned, are not usually tested as pilots before they are fully implemented. If a certain idea seems correct or promising, it is enacted into law and/or tied to funding requirements for programs. Sometimes these laws and policies result

in significant advances for the welfare of children; sometimes, they produce unintended consequences detrimental to the delivery of efficient and effective services. In this latter case, it is imperative that those charged with the delivery of child welfare programs challenge these policies and statutes, demonstrate their flaws, and work to change them. In that regard, they need the wisdom and legal expertise of County Counsel.

Any serious reform undertaken will require a different legal support philosophy and sense of mission, one in which Counsel attempts to analyze the derivation of potential legal or political impediments to reform and to assist departments in discovering legal ways around these potential restrictions to better serve children. Some balance between the protection of the County from lawsuits and the protection of children from abuse must be found. A philosophical shift from "what cannot be done" to "how can we get it done" is essential.

II. THE TRANSFORMATION IMPERATIVE

The Commission believes a major transformation of the County's mission, philosophy, organizational structure, and methods of evaluation, measurement and accountability regarding its responsibilities toward the welfare of children is essential. Nothing short of such a comprehensive approach to reform will create a truly protective and nurturing environment for the children of Los Angeles County.

A. Mission

Many critical needs compete for the resources of the County of Los Angeles as it attempts to fulfill its mission to protect and serve its sprawling and diverse population. There are many worthy programs as well as various special interests constantly lobbying the Board of Supervisors for more resources and services. The Commission affirms that among all these competing needs and interests, none is more important to the establishment of a civilized society than the requirement to protect and nurture the children of the community. This is true in part because it defines the nature of an enlightened society to care for and protect the most vulnerable among us, the children. It is also true because, in doing so, we insure the health and welfare of generations to come.

As an essential component of the transformative process we envision, we strongly recommend the County place the welfare of the children under its charge as its HIGHEST PRIORITY. Further, the County Board of Supervisors must provide the vigilant oversight and resources required to adequately fulfill this critical government responsibility. Without this level of conscious commitment by the top levels of County government, we predict attempts at reform will continue to fail.

B. Philosophy

The Commission found it difficult to describe what, if any, overarching philosophy with regard to child welfare guides the County's various programs for children. Many county departments have some responsibilities for some aspects of a child's life.* Only the Department of Child and Family Services role is totally dedicated to children's welfare. Although this Office also must

depend on the services of other County departments to fulfill its broad mandate, it has no official authority save moral suasion to affect how and where other departments establish priorities and place resources regarding children. There exists no mechanism to enforce or even conceive of an overarching process whereby all of the resources of the County are brought together to focus on the child within some coherent approach to effectiveness.

The Commission believes the County should adopt a CHILD-CENTERED philosophy, which organizes all County child welfare programs (broadly conceived) and resources in a manner that place's the child's welfare first, in all circumstances. The desirability of such a philosophy should be self-evident. Unfortunately, over time, the nature of bureaucracies eventually elevates the interests of employees, supervisors, administrators and bureaucratic structures in a manner that often subjugates solutions clearly in the best interests of the child. Furthermore, since best practices throughout the nation clearly prove that the most effective means of insuring child safety and welfare is to remediate and strengthen the role of the FAMILY, we urge this "child centered" philosophy be implemented through a strong focus on and commitment to families.

If we analyze the many problems identified within our child welfare system, we can see how such practices would have been abandoned or never allowed in the first place if a child centered and family focused philosophy had been at the core of all programs and practices.

For example, if we cared about the child first and:

If we knew that removing a child from his/her home would be THE critical decision point for the success or failure of the child in the system, and that keeping the child in the home usually has a better result than moving him into the child welfare system, and that the Department of Family and Children's Services frequently sends the least experienced of its social workers into the field to make these critical decisions, and that 75% of the deaths reported could be traced precisely to this flawed front end intake process, we surely would never have created such a system.

If we knew that 50% of all children in foster care end up homeless, institutionalized or incarcerated upon aging out of the system at 18 years of age, and only 4% received any higher education, we would not tolerate such a negligent system.

If we knew that, even acknowledging a child's fundamental need for stability, the average number of different foster home placements experienced by a child in the system would be seven, and that changing placements frequently would require the changing of schools, and that the school records of many children would get lost in such transitions, and that because of the lack of coherent school record tracking, children frequently would be required to re-take course work already completed thus inhibiting their ability to finish school in a timely manner, we would never have created or tolerated the creation of such a system.

If we knew that children placed in foster care undertaken by a family member fare better than children placed in foster care outside of the family, and that the system of compensation for outside of family foster parents ranges from 2.3 to 3.5 times greater than that received by family foster parents (who frequently are in greater socio-economic need than outside foster parents),

surely we would question a system that provides disincentives to undertake the very practice of kinship care that produces the best results for the child.

These are examples of real conditions within the present child welfare system; they represent but a few of the many unintended consequences resulting from the non- strategic reactivity of bureaucratic organizations. For these reasons, the Commission urges a total rethinking of the way in which the County of Los Angeles fulfills its responsibility to the welfare of the children of the County. We urge the County to embrace a CHILD-CENTERED philosophy as the foundation for all programs and to adopt the organizational and accountability structure defined in this report designed to ensure the implementation of this philosophy.

C. Organizational Transformation

During its interactions with service providers, the Commission was stunned by the lack of any sense of urgency regarding the need for reform and the pervasive expressions of negativity and futility with which many interviewees responded to proposals for improvement.

The Commission strongly believes, therefore, that sustainable reform will require the Board of Supervisors to declare something akin to a STATE of EMERGENCY within the child welfare system, since clearly, the present system presents an existential threat to the safety and protection of our children.

An appropriate metaphor for the extensive campaign necessary to produce critical bureaucratic change can be found in the manner in which allied nations at war work together to save their way of life. We do not regard such a comparison as melodramatic, since here we are addressing a situation in which babies die. As such, we believe a sense of urgency is not only justified, but essential to remind all concerned, every individual working in every department responsible in anyway for child welfare, of the gravity of their tasks.

During the Second World War, when the Allied Forces were confronted with the task of defending their nations against attacks which threatened their very existence, each country did not retreat to its own conference room, deploy its own military resources based on its individual priorities, and sit back and hope that some among them might be inclined to talk and plan together. Had that been the case, the outcome certainly would have been a disaster for the future of the free world.

Instead, the Allies saw the need to create a strategic approach, utilizing every nation's resources to focus on the critical achievement of the goal of winning the War. In doing so, they created a Joint Command of Allied Forces, which then appointed a Supreme Commander of the Allied Forces for each of the two theaters of the War, a single individual with the authority to direct when, where and how all troops and resources would be brought to bear on winning the War. The structure did not allow for individual branches of service in different countries to decline to participate because they wanted to use their resources in some other way, had their eye on a different beach head to invade, had a different philosophy or plan for winning the war, or wanted to save their resources for some narrower parochial goal.

The Supreme Commander and his staff continuously monitored and evaluated the strategies and tactics being pursued, and if a particular strategy did not work, they reassessed resource and troop deployment, revised the plan, and modified and implemented new orders to the troops. Further, they did so as rapidly and efficiently as humanly possible, because lives were at stake as well as the future of their nations. The Commission believes this metaphor is highly appropriate: lives are at stake as is the future of a generation.

III. SUBCOMMITTEE RECOMMENDATIONS

1. Implement a total reorganization of the structure and leadership authority within which all programs related to children operate.

2. Create a comprehensive strategic planning process resulting in a single statement of measurable goals directing all relevant programs in all county departments.

3. Institute an annual zero based budget process in which of ALL private, federal, state, and county resources related to child welfare are tied solely to the implementation of the countywide strategic plan.

4. Link the process of budget allocation to a system of evaluation in which the success of all aspects of the program is measured against previously established measurable outcomes.

5. Institute a process of continuous improvement through an on going streamlining of organizational structures, annual strategic planning, measurable goal setting, evaluation of program effectiveness, and rigorous application of relevant research findings with the consequent appropriate reallocation of resources.

A. Organizational Structure

The diffusion of authority and lack of an overarching vision for child welfare is one of the main impediments to an effective child oriented countywide program. Given the many departments and programs involved in this area, the multitude of funding sources and the dynamic environment impacting child welfare demands, no single entity now exists with the authority and expertise to pull these programs together in an effective way.

The Commission, therefore, recommends the County Board of Supervisors create the position of Los Angeles County Executive Director of Child Protection, and delegate to that position the countywide authority to coordinate, plan, and implement one UNIFIED county welfare system. This position would be unique in the County, reporting directly to the Board of Supervisors and having resource allocation input and oversight over all resources in all departments relevant to supporting the child welfare system. This position would have the responsibility and authority to implement the aspects of transformation outlined above.
The person appointed to this critical position will have to have special leadership attributes. The position will require a change agent, experienced in leading change in large entrenched organizations, comfortable in challenging long held but outdated policies, gifted in problem solving, committed to the critical importance of this reform, skilled at communicating

persuasively, able to lead and guide in a collaborative setting, persistent in the face of resistance, and unafraid of risk. While we realize this combination of leadership traits may be difficult to find in one person, the challenge of effecting change of this magnitude will require it.

To effectively guide this transformation, the Executive Director will need a small, highly trained staff to provide the kind of information, analysis, and expertise enabling the coalition of departments to meet these strategic goals. Legal expertise must reside in the Office of the Executive Director skilled in finding creative solutions to legal and political impediments to reform, a proactive force helpful and capable of overcoming ever present forces negatively reactive to change. Budget analysts capable of performing strategic analysis and executing comprehensive budget reviews inclusive of all County resources devoted to children will be essential to the strategic planning and zero based budget allocation process proposed.
Any existing research staff and activity in the County regarding child welfare should be moved into this office to guarantee that best practices are continuously explored and adopted, and to conduct interdepartmental pilot programs which show promise for countywide generalization. If such staff and activities are not now present in any of the departments dealing with child protection, the Executive Director of Child Protection should create such a function within his/her office. Finally, measurement and program evaluation experts will be key to the process of strategic planning, ensuring that all strategic goals are measurable and that such goals are regularly evaluated for effectiveness.

The Commission is aware that this recommendation might appear to some as just an additional bureaucratic layer and question why the existing county departments could not implement many of these recommendations without the creation of such an entity. We wish to emphasis in the strongest terms that, to the contrary, this new office must be operated as a force to cut through bureaucratic impediments inherent in the county silos. It must never be allowed to become yet another obstacle impeding the implementation of reform. This new entity must be conceived as a powerful engine with the knowledge, authority and will to slice right through bureaucratic barriers. The charge to the holder of this new position and its related staff is to lead in the establishment of measureable countywide goals in child welfare and to find the most effective and efficient methods of implementing and sustaining them. Further, this team must subject these goal-oriented programs to a process of continuous evaluation and improvement.

After extensive hearings and interviews with a broad array of County service providers and administrative leaders, we are convinced that no existing county entity could function as we describe. The supervision and budgetary support the CEO's office now provides to the cluster most relevant to children's issues simply does not have the resources or kind of expertise necessary to accomplish what needs to be done. Nor should it. The CEO's administrative purview is vast, its responsibilities enormous. It should not be required to provide the kind of single laser focus and specific expertise this challenge requires, though its assistance will be critical in helping the new entity accomplish the analysis necessary to implement a zero based budget. That applies equally to County Counsel in aiding the new entity as it confronts legal constraints.

Finally, in considering the preliminary investment the County will make in acquiring management talent and properly organizing the County's child welfare expertise and services,

we believe the investment will not only enhance the welfare of our children, it will also result in savings and program reallocations surpassing any initial investment.

B. Strategic Planning Process

The seminal task for the holder of this leadership position will be to undertake a continuous comprehensive strategic planning process, whereby the Executive Director, in close collaboration with all relevant department heads and appropriate community representatives, leads a comprehensive strategic planning process to connect, guide, and implement all child welfare services in the County and to articulate clearly measurable goals and time frames.

The objective is not to create a document that at one point in time is adopted, put on a shelf and forgotten. The commission endorses the practice of an ongoing strategic planning process, one in which goals are constantly modified and updated, revised for the future based on past success or failure or changing environmental conditions.

The ongoing nature of this process and the need for close collaboration between all departments will require the Executive Director to establish a working cabinet of departmental leaders, and a deliberative process whereby input and expertise from all participants is an integral part of the assessment and decision making process. We believe this inclusive deliberative policy and priority setting process is critical to the success of such transformation, just as we believe, in the final determination, one individual must be empowered to make the countywide program decisions as well as be accountable for their outcomes.

C. Zero-Based Budget Process

Throughout its many hearings and interviews, the Commission heard repeatedly of the need for more resources to implement any modification or reform suggested. In decrying the heavy caseload, the social workers asked for precise numbers of increases in personnel. In his response to the Commission's Interim Report recommendation regarding the pairing of Public Health nurses with a DCFS social worker, Director Browning relayed the Department of Public Health's stated need to hire an additional 80 Public Health nurses. The Commission also heard concerns, even from some of its own members, that such reforms would be too expensive.

These concerns and constant requests for more resources are based on the bureaucratic assumption that all existing resources deployed within the county system are being put to the most effective and highest priority uses; it assumes that any change must be carried out in addition to all programs already in place. The Commission strongly rejects this assumption. Such thinking is not only incorrect; it ignores the potential savings that the leveraging of resources can bring. It is just the kind of bureaucratic reasoning that forgoes the monumental impact on the effectiveness of resource allocation and quality programming that can be achieved by a transformative strategic realignment of people and services toward a common goal.

During our hearings, in pursuit of locating financial information relevant to this line of inquiry, the Commission questioned relevant county personnel. We were not able to discover any central place that could provide the Commission with the total number of resources now devoted

to the welfare of children within the County. Nor could we ascertain the percentage of the total County budget that is allocated to child welfare. As a consequence, the commission cannot offer a prediction of cost savings that will result from such a transformation, nor can it accurately project its ultimate financial impact on the County, positively or negatively. Such projections should be possible. That the Commission was unable to derive the data to offer them, gives even greater significance to the need for a fundamental transformation of the child welfare budget process.

As part of the organizational transformation process, therefore, the Commission recommends a complete rethinking of the budget process for programs dealing with child welfare. To the extent possible, within the constraints of government grants, memoranda of understanding, and union contracts, the County must enact a zero based budget process. This will require that every year, in determining budget allocations for child welfare programs, the total budget must be analyzed and its programs measured for strategic relevance and effectiveness. The "total" budget should be defined as including all resources applicable to child welfare from all sources (County, State, Federal, private) regardless of how these resources were previously deployed. The practice of considering only incremental additions to existing budgets, as is now the case, protects inefficiency, stifles inter-program innovation, and makes continuous improvement impossible.

A comprehensive zero based budget process facilitates the reallocation of resources and services when necessary to support strategic countywide goals, meet changing demands, and support innovations. As effective programs are put in place that produce declines in resource demands from one arena, those savings can be reallocated to different problem areas or, if possible, reduce the overall resource demands child welfare programs place on the overall County budget.

The long-term effects of such a budgetary approach can be dramatic. Programmatic success in the achievement of one strategic goal can provide the resources necessary to implement another strategic goal. Under such a system, for example, the strategic planning and budgeting process might allocate significantly more resources than at present to the front end of the intake system. If this Investment in a higher quality and more accurate assessment of at risk children succeeds in greatly reducing the number of children placed into the welfare system, the savings would be geometric and long term and the children will fare better. The resulting savings could be strategically reassigned to help support services to more troubled families enabling them to keep their children in the home and out of the system. Or, with significant savings from organizational realignment and a countywide child welfare budget perspective, savings from a more effective intake process could be reallocated to services providing better education and life training for older foster children to enable them to experience a successful transition from the foster care system.

D. Measurement And Evaluation

The Commission's recommendations regarding the transformation of the child welfare system will only result in success if a consistent and rigorous system is in place to guarantee measureable outcomes of success in achieving strategic goals. Evaluating these measurable outcomes must become a component of the annual planning and allocation process. Such a system must enable successful pilot programs to be generalized quickly throughout the whole system; likewise, it must facilitate the speedy discontinuance of failed practices. The discipline

and rigor inherent in such an evaluation and budget process is not a routine part of most government systems, though it is the essential element of successful corporate management. While it may be easier to measure results in terms of profits, the impact of programs on the lives and welfare of children is measurable and must be done.

APPENDIX 4

Los Angeles County
Blue Ribbon Commission on Child Protection

Interim Report
December 30, 2013

On June 25, 2013, the Los Angeles County Board of Supervisors (Board) created the Blue Ribbon Commission on Child Protection (Commission), following the tragic death of eight year-old Gabriel Fernandez. The horrific killing of this young boy, allegedly at the hands of his caregivers, was seen as another failure by Los Angeles County (County) to protect children under its supervision. In its motion, the Board charged the Commission to:

- Review previously delayed or failed efforts to implement reforms and provide recommendations for a feasible plan of action to expeditiously implement needed reforms;

- Review the systemic, structural and organizational barriers to effective performance. These may include such factors as the current structure, scope of the Department of Children and Family Services (DCFS) and relevant County departments, including the departments of Health Services, Mental Health, Public Health, and Sheriff, the District Attorney, the Dependency Court and commissions, various memoranda of understanding, and the relationship of DCFS to the Board; and

- Review, at its discretion, the child protection failures, including DCFS policies and cases.

The Board instructed the Commission to provide an Interim Report by December 31, 2013, and to issue its Final Report by April 18, 2014. While most of the Commission's findings and recommendations will be provided in April, this Interim Report describes the information-gathering process to date, sets forth initial key findings, and makes a limited set of preliminary recommendations for immediate implementation.

The Commission fully recognizes the urgent need to reform the County's child protection system, as well as the direct request by the Board to provide "a feasible plan of action to expeditiously implement needed reforms." **To improve child safety and prevent child maltreatment fatalities, the Commission urges the Board to adopt the concrete steps proposed in this Interim Report to begin immediate reform of the current "dysfunctional"**

County child protection system. These proposals, set forth in Section II below, provide an opportunity to make children safer *now*.

I. INFORMATION GATHERING

Given the gravity of the task and the multitude of recommendations for reform the Board has received over the years, the Commission determined that the Board deserves more than a cursory review leading to prejudged conclusions. **A multi-system, comprehensive assessment is warranted to fundamentally improve child safety.** The effort had to be more than a compilation or repetition of previous recommendations. Therefore, the Commission has pursued a fresh perspective and process that is comprehensive, inclusive, and transparent, including:

- **Eleven public hearings** at which the following Los Angeles County departments and nonprofit organizations provided testimony: Department of Children and Family Services (DCFS); Sheriff's Department (LASD); Department of Mental Health (DMH); District Attorney's Office (DA); Department of Health Services (DHS); Department of Public Health (DPH); Department of Coroner; Department of Public Social Services (DPSS); the Inter-Agency Council on Child Abuse and Neglect (ICAN); First 5 LA; the Commission for Children and Families; Dependency Court; Domestic Violence Council; LAC+USC Medical Center; University of Southern California School of Social Work; Children's Law Center of California; Alliance for Children's Rights; Public Counsel; Child Welfare Initiative; Stuart House; relative caregiver organizations, including Kinship in Action, Community Coalition, Grandparents as Parents, and ROCK; representatives from the Countywide Community Child Welfare Coalition, including SHIELDS for Families, Project IMPACT, Bienvenidos, Para Los Niños, and Children's Institute, Inc.; and members of the Association of Community Human Service Agencies, including Optimist Youth Homes & Family Services, David and Margaret Youth and Family Services, and Penny Lane Centers. The Commission also received important comments from many members of the public.

- **Interviews with close to 300 stakeholders** across all program areas related to child safety. Under the direction of a Commission work group, the University of Southern California School of Social Work took primary responsibility for organizing and conducting these interviews. Interviews were conducted in each Supervisorial District and included conversations with representatives of DCFS, the Dependency Court, DHS, DPH, the Commission for Children and Families, Service Employees International Union leadership, selected local hospitals and community health services, Los Angeles and Long Beach Unified School Districts, faith-based organizations, and community nonprofit programs contracting with DCFS, DMH, and the Department of Probation. Interviews were conducted with providers representing a complete spectrum of services, ranging from prevention, early diagnosis and investigation, to foster care, intensive treatment, residential care, and transitional support. A total of 298 persons provided input in one of either 32 focus groups or 34 in-person meetings.

- **Focus groups with the people most impacted by the policies and practices of the child welfare system.** Under the direction of another Commission work group with significant support from Casey Family Programs and the USC School of Social Work,

focus groups and interviews are underway with the following client populations: children and youth 13-17 years old; transition age youth 18-25 years old; formal and informal kinship caregivers; birth parents; and foster and adoptive parents.

- **Review of relevant previous recommendations made to DCFS and other County agencies.** In consultation with Walter R. McDonald & Associates, Inc. (WRMA), a database was created to organize and categorize prior recommendations related to child protection and safety dating back to 2008. An initial review and analysis of over 700 recommendations contained in 29 documents was completed. Additional analysis is planned to inform the Final Report.

- **One-on-one, in-depth interviews with leaders in the child welfare field, conducted by Commissioners and Commission staff.** These include extensive interviews with members of law enforcement, DCFS, DHS, DMH, and the District Attorney's Office, as well as education and community leaders.

- **Review of best practices and relevant reports on child abuse.** The Commission is reviewing promising practices and reports considered and/or utilized in other jurisdictions to assess what can be learned and applied in Los Angeles County.

- **Constituent correspondence received by the Commission.** Constituent letters and email inquiries were received and reviewed.

II. KEY FINDINGS AND PRELIMINARY RECOMMENDATIONS

Of one thing the Commission is certain: The children of Los Angeles County must be safer than they are at present. The Blue Ribbon Commission on Child Protection will issue a complete set of recommendations in its April 18, 2014, Final Report to the Board of Supervisors. The Commission has decided to present in this Interim Report ten recommendations that lend themselves to immediate action.

Accountability

Hundreds of child welfare-related recommendations have been offered to the Board over the past eight years. **Before any set of recommendations can be effectively implemented, a fundamental change in County structure and culture must occur.**

The failure to protect children cannot be attributed to one agency or department. DCFS is not and cannot be viewed as solely responsible for all aspects of child protection. Under its current structure, the County child welfare system is comprised of multiple departments and agencies that struggle to communicate effectively, plan jointly for children and families at risk, combine funding resources, and work together on integrated planning to improve child outcomes. While some advances have been made through partnership initiatives, such as the Violence Intervention Program at LAC+USC Medical Center and Stuart House at UCLA Medical Center, these collaborative models are the exception rather than the rule.

The County's current siloed approach often re-victimizes children and fails to strengthen family caregiving. There must be a fundamental cultural and structural shift to a multi-disciplinary system of County departments with common priorities, shared responsibilities, and collaborative problem solving. Child safety must become a priority across these departments coupled with mechanisms to work collaboratively. The Board should hold departments accountable for developing structured inter-agency partnerships that reflect a County-wide systemic approach to improve child safety. Multi-sector and multi-agency strategies are essential components of a comprehensive system that protects children.

Currently, the County has no system for managing, vetting, implementing, and assessing recommendations related to child safety and well-being. This includes process and outcome assessments for child protection. These are essential in the management of any system of care and to the provision of consistent and meaningful information about the effectiveness of implemented reforms.

In response to the Board's direction that the Commission review "structural and organizational barriers to effective performance," the Commission proposes that one coordinating entity be identified to work with the Board to ensure that all relevant departments are accountable for improved child safety. That entity should oversee the development of joint strategic plans, including the combining of resources. It also should be charged with consolidating, prioritizing, implementing, and evaluating reforms mandated by the Board. In its Final Report, the Commission will highlight the important components of such an entity and recommend a streamlined system for vetting and implementing needed reforms. Ultimately, the Board of Supervisors and County leadership should be able to answer confidently the question of whether the adopted strategies are improving child safety.

Recommendations:

1. **All previous recommendations undergoing implementation by DCFS should be reviewed and prioritized to ensure that implementation will improve child safety and/or contribute to the effectiveness of DCFS's mission.**

2. **The Board and County leadership must develop additional finely-tuned process and outcome measures, other than tragic child fatalities, to assess system performance.**

Children Age Five and Under

The Commission believes that improved child safety depends on identifying children who are at the greatest risk for a serious or fatal injury and providing them and their families with high-quality, accessible, and appropriate services. Dr. Emily Putnam Hornstein, Director of the Children's Data Network in the School of Social Work at the University of Southern California, provided the Commission with crucial information about children at risk:

- Children under five years old are at the greatest risk of death as a result of abuse or neglect. Fatality rates are highest among infants under age one.

- A report to a child protection hotline is the single best predictor of a child's injury-related death before age five, including both deaths due to maltreatment and deaths due to unintentional injury. This is true regardless of whether DCFS legally substantiates the abuse or neglect.
- The rate of death is highest during infancy (under 12 months).
- More than three quarters of the roughly 8,000 infants who are reported to DCFS each year remained with their families of origin after the first hotline report – and 50% were subsequently reported for a second report of maltreatment before age five.

National child fatality trends indicate that very young children (ages four and younger) are the most frequent victims of child fatalities. National Child Abuse and Neglect Data System (NCANDS) data for 2011 demonstrated that children younger than one year accounted for 42.4% of fatalities and children younger than four years accounted for four-fifths (81.6%) of fatalities. A recent report by the Inter-Agency Council on Child Abuse and Neglect (ICAN) and other reports suggest similar trends in Los Angeles County.

Given that fatality risks are most pronounced for children reported to child protective services during their first year of life, this is likely a period during which service interventions are most impactful and protective. Unfortunately, among these infants, there is very little data from which to determine how many families were successfully engaged in services.

Recommendation:

3. **The County can measurably and immediately improve child safety by requiring all departments to target combined resources and high quality services, including prevention services, toward children under the age of five.**

Law Enforcement

In addition to DCFS, an independent, second set of eyes assessing the well-being of a child can be the difference between a safe child and one who is seriously injured or dies. **The mandated obligation of law enforcement to investigate possible criminal behavior related to child safety should be more aggressively and consistently enforced.**

Allegations originating from DCFS through the Electronic Suspected Child Abuse Reporting System (E-SCARS) should be treated with equal importance as calls made directly to a law enforcement agency from a resident or mandated reporter. E-SCARS is the County's innovative information sharing system available for use by DCFS, every law enforcement agency in the County, and by City and County prosecutors.

The District Attorney's Office can play a major role in improving law enforcement policies and practices. The DA's Office regularly interacts with all of the County's 46 law enforcement agencies, prosecuting appropriate criminal cases. It also tracks the response of these agencies to child abuse cases, including the number of cases referred for prosecution, how each entity utilizes E-SCARS, varying methods of retrieving Suspected Child Abuse Reports (SCARs), and the documented/reported amount of time it takes to begin to investigate SCARs. The DA's Office could ensure appropriate cross-reporting by all LA County law enforcement entities and

provide needed training about their responsibilities and best practices. The Office could help address the following:

- Failure by some law enforcement entities to cross-report SCARs to DCFS and the DA's Office and document their actions;
- Different standards among law enforcement agencies for investigating reports of alleged abuse;
- Insufficient support for updating and maintaining E-SCARS and for needed oversight by the DA's Office;
- Inadequate methods of retrieving cross-reported SCARs so that some are not seen for days; and
- The need for mandatory and continuing training for all levels of law enforcement personnel on handling child safety cases and on their respective responsibilities. The Commission also is looking into the effectiveness of cross-training law enforcement with social work and mental health personnel.

Recommendations:

4. **All Sheriff's deputies and local law enforcement agencies within the County of Los Angeles must cross-report every child abuse allegation to DCFS, as required by State law. In addition, it should be documented that a cross-report was made, for example, in a police report or law enforcement log.**

5. **E-SCARS should be utilized fully by all relevant agencies and receive the necessary support to be well-maintained and enhanced.**

6. **The District Attorney's Office should increase its oversight of the law enforcement response and sharing of information, including cross-reporting between DCFS and law enforcement agencies, to ensure that each agency carries out its mandated investigative response.**

7. **To avoid placement delays and improve child safety, law enforcement and DCFS staff should be co-located, or otherwise collaborate closely, to increase the speed of background checks for relatives and other potential care providers.**

Health Services

Medical or developmental issues may be symptoms of child abuse or neglect. When those signs are missed or not addressed, the risk of repeat abuse, serious injury or even death occurs. In 2006, DHS, DCFS, and DMH partnered to develop the County-wide Medical Hub Program to build a system of medical and mental health care that, in partnership with DCFS, would guarantee that every child detained or at risk for detention had access to expert medical/mental health evaluations to promote appropriate interventions and child safety. Ultimately, the Hubs were designed to provide the foundation for building a medical/mental health home for children in foster care.

Currently, six Hub clinics provide a limited number of medical and other services under the auspices of the DHS. All of them have out-stationed DCFS workers as partners and provide expert forensic evaluations, as well as initial medical evaluations of children detained by DCFS and placed in out-of-home care. However, only one, the Hub at LAC+USC Medical Center, provides comprehensive services supported by a number of departments and 24-hour, 7-day a week inter-agency services.

The Hubs need immediate support to align them with the original goals of providing the following services in each Supervisorial District:

- Expert forensic, medical, and mental health evaluations for every child detained or at risk for detention;
- Expert forensic, medical, and mental health assessments for children at the time their families receive preservation or reunification services;
- Re-evaluation for children who were in foster care or who had unsuccessful foster placements, remained in group homes for longer than six months, or returned home either through family preservation programs or reunification;
- A mandated "medical home" and ongoing services for children who are in foster care; and
- A "re-entry" service for children who were followed by both the probation and the child welfare systems.

Expansion of this Hub system will help save children's lives and enable DCFS to better evaluate and appropriately place children.

Assessments should be conducted to identify each Hub's strengths and weaknesses and devise strategies to meet the needs of their geographic area. For example, Martin Luther King Medical Center (MLK) is the perfect site to assess immediately and then expand services to meet the pressing needs of high-risk families in Service Planning Area 6 and address the needs of sexually exploited girls found predominantly close to MLK clinics.

In addition to expanding Hub involvement, the skills and expertise of Public Health Nurses should be used to improve and enhance DCFS's investigative processes. Their participation would immediately improve decision-making. This approach has been utilized successfully in several communities around the country.

The Department of Public Health's evidence-based home visiting program has reduced the risk of subsequent abuse and neglect. These critical services should be expanded to reach all children under age one who are seen at a Medical Hub. DCFS must remain in continuous contact with these medical personnel to facilitate appropriate detention and placement decisions, as well as service referrals.

Recommendations:

8. **All children entering placement and children under age one whose cases are investigated by DCFS should be screened at a Medical Hub. Children placed in out-**

of-home care or served by DCFS in their homes should have ongoing health care provided by physicians at the Medical Hubs.

9. **A Public Health Nurse should be paired with a DCFS social worker in child abuse or neglect investigations of all children from birth to at least age one.**

10. **The Department of Public Health's evidence-based home visit service should be made available to all children under age one who are seen at a Medical Hub.**

III. IMPLEMENTATION OF LAW ENFORCEMENT AND HEALTH SERVICES RECOMMENDATIONS

Even at this early juncture, the Board and the County collectively have an opportunity to demonstrate their commitment to improve child safety by initiating implementation of the Commission's preliminary recommendations. Ultimately, the Commission will be recommending that one entity oversee implementation of the Final Report's recommendations, as set forth in the Accountability section. In the meantime, in concert with the Board's direction that the Commission review "structural and organizational barriers to effective performance," the Commission proposes the following implementation steps:

- The Board should consider and endorse the law enforcement and health services recommendations through a Board vote.
- In health services and in law enforcement, one agency, department or stakeholder should be designated by the Board to bring relevant decision-makers together and lead the development of a concrete plan for implementation of the recommendations. The Commission further recommends that the Board designate a lead entity by the end of January 2014.
- The lead agency must be empowered by the Board to have the ability to transcend structure and propose the movement of financial and staff resources without regard to department lines.
- In each area, the lead entity should develop an implementation plan that includes timelines, projected improvements in safety outcomes for children, and milestones to indicate whether implementation is on track. The implementation plans should be completed and presented to the Board by mid-March 2014.

The Commission believes that the District Attorney's Office should have lead responsibility for implementation of the law enforcement recommendations, with the participation of the Sheriff's Department, DCFS, and the Chief Executive Office (CEO). With respect to the health services recommendations, the leadership from the Violence Intervention Program at LAC+USC Medical Center (VIP), in conjunction with the Department of Health Services, should oversee an assessment of the current capacity of all Hubs and work with the CEO, Departments of Public Health and Mental Health, as well as DCFS, to implement needed reforms and propose cross-sector funding for new initiatives to the Board. VIP is the most comprehensive Hub that is closest to meeting articulated goals and has the greatest ability to conduct a neutral assessment.

The Commission will remain closely involved with these initiatives to support this restructuring process and monitor the implementation of the recommendations. The progress made and obstacles encountered will inform the Commission's Final Report. If adopted, the coordinating structure that the Commission will define in its Final Report would play a major role in the final implementation of these recommendations.

IV. CONCLUSION

Immediate implementation of the Commission's preliminary law enforcement and health services recommendations will improve child safety. The Commission will continue to develop a roadmap for making the County's generally fragmented child protection system into an integrated, interdisciplinary, and effective network to help all children reach their full potential.

In its ongoing work, the Commission is investigating a wide range of important issues that could reduce the risk of future abuse and neglect to children. Topics will include, but not be limited to: DCFS culture, workload, and training; foster care practices; support for relative caregivers; legislative impediments to child safety; the accessibility and quality of mental health services; the role of technology to facilitate cross-department communication and collaboration; programs for transition age youth; domestic violence and substance abuse programs; and the roles of the Dependency Court, the educational system, community-based organizations, prevention services, and group homes.

The Commission thanks the Board of Supervisors for the opportunity to examine the obstacles to creating an effective child safety system in Los Angeles County and provide a Final Report in April with comprehensive recommendations for reform.

APPENDIX 5

JACKIE LACEY
LOS ANGELES COUNTY DISTRICT ATTORNEY

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April 3, 2014

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

BOARD MOTION – FEBRUARY 4, 2014
AGENDA ITEM NO. 4 - IMPLEMENTING THE PRELIMINARY RECOMMENDATIONS OF THE BLUE RIBBON COMMISSION

On February 4, 2014, the Board requested that the "District Attorney develop the necessary protocols with the Los Angeles County Sheriff's Department (LASD) and other law enforcement agencies to ensure that every child abuse allegation is cross-reported as required by State law and ensure that the Electronic Suspected Child Abuse Reporting System (E-SCARS) is fully utilized by all relevant agencies, and request that the District Attorney or her representative report back to the Board in writing within 45 days."

The District Attorney's Office has reviewed the Blue Ribbon Commission's Interim Report to your Board dated December 30, 2013, and previously responded that the recommendations with respect to the role of the District Attorney's Office are in line with how the District Attorney envisions the Office contributing to the creation of an effective child safety system.

In response to the Board's request to report back, we have prepared a proposal that will significantly increase the department's ability to ensure E-SCARS is fully understood and utilized by all partner agencies. The proposal will expand our E-SCARS Unit staffing by one Deputy District Attorney IV and three Paralegals in order to create a program that will have the concurrent benefit of acting as an impetus to improve the performance of all partner agencies leading to improved compliance with statutory law and increased safety and protection for children. These new positions have been requested in our 2014/15 official budget. Our proposal will also do the following:

1. Develop and deliver training to local law enforcement and the Department of Children and Family Services (DCFS) relative to statutory obligations as mandated reporters and cross reporters under the Child Abuse and Neglect Reporting Act (CANRA).

2. Develop and deliver training to prosecutors on statutory obligations of all stakeholders under CANRA, including possible violations of the criminal law.

3. Assume significantly increased auditing abilities for compliance by law enforcement agencies and DCFS with CANRA; including meeting with high-level officials at law enforcement agencies and DCFS to develop corrective action plans to address deficits in the performance.

4. Conduct ongoing assessments of gaps in existing laws for effective child protection; drafting proposed legislation designed to address these gaps; and acting as a subject matter expert for testimony in the legislative process.

5. Identify opportunities to work effectively and efficiently with child protection stakeholders to address issues related to protection of children and leading efforts to develop research based strategies for the prevention of child abuse and neglect.

Enclosed is our proposal to expand our oversight of E-SCARS and cross-reporting by mandated reporters and move towards improved child safety in Los Angeles County.

Respectfully submitted,

JACKIE LACEY
District Attorney

pc

Enclosure

c: Executive Officer, Board of Supervisors
Chief Executive Officer
Blue Ribbon Commission

LOS ANGELES COUNTY DISTRICT ATTORNEY'S OFFICE
E-SCARS EXPANSION

In order to make certain that every child abuse allegation is cross-reported and ensure that the Electronic Suspected Child Abuse Reports System (E-SCARS) is fully utilized by all relevant agencies, it is proposed that an E-SCARS Unit be created in the Los Angeles County District Attorney's Office (LADA). The E-SCARS Unit will be comprised of a Supervising Deputy District Attorney at the level of Deputy District Attorney IV and three additional Paralegals. Such a unit will enable the LADA to more efficiently and accurately comply with its duty to audit Suspected Child Abuse Reports (SCAR) cross-reporting in Los Angeles County.

Deputy District Attorney IV's Role:

A Deputy District Attorney (DDA) IV will serve as a Deputy-in-Charge (DIC) of the E-SCARS Unit with the sole responsibility of managing and supervising the work and personnel assigned to this new unit. The DIC will not carry a caseload. The duties of the E-SCARS DIC will include but not be limited to the following:

- Chair the E-SCARS Steering Committee.
- Supervise the auditing of E-SCARS usage by DDAs, the Department of Children and Family Services (DCFS), and law enforcement agencies as conducted by the enhanced Paralegal staff dedicated to E-SCARS.
- Schedule and conduct regular E-SCARS training for all law enforcement agencies and LADA branch and area offices throughout the County. (Currently, training is scheduled on an "as needed" and "as requested" basis.)
    - Law enforcement training will center on the importance of cross-reporting to DCFS, methods used in investigating child abuse, using E-SCARS as an investigative tool, and how to navigate E-SCARS.
    - The DDA training will focus on LADA E-SCARS procedures, discovery responsibilities, evidentiary issues and navigating through E-SCARS.
- Develop, coordinate and host an annual one-day E-SCARS symposium through the LADA Criminal Justice Institute.
- Actively seek to procure grants to update and enhance the management of E-SCARS full compliance.
- Complete a Memorandum of Understanding and Operational Agreement with the LADA, Los Angeles Sheriff Department (LASD), DCFS and other partners to increase and improve usage of E-SCARS and cross-reporting.
- Develop and implement policies and procedures for audit findings.
- Directly supervise four Paralegals and prepare yearly performance reviews.
- Consult with investigators regarding E-SCARS in which the narrative is inconsistent with the "No Crime Suspected" status.

- Play an active role in the Victim Impact Program related training, meetings, etc., in order to heighten awareness of E-SCARS.

Paralegals' Duties:

The E-SCARS Unit will be staffed with four Paralegals. Each Paralegal will be assigned to a specific law enforcement agency and/or DCFS. Their responsibilities will include developing and fostering positive working relationships with assigned agencies as well as generating monthly, quarterly and yearly reports for those agencies. The responsibilities will be divided as follows:

- Los Angeles Police Department (LAPD) Paralegal
    - Audit all SCARs designated to LAPD.
- LASD Paralegal
    - Audit all SCARs designated to LASD.
- DCFS Paralegal
    - Audit DCFS conclusions to SCARs.
    - Identify and research discrepancies between DCFS findings and law enforcement findings.
- Independent law enforcement agencies and LADA Paralegal
    - Audit all SCARs assigned to the 44 independent law enforcement agencies.
    - Monitor LADA usage of E-SCARS.

The Paralegals will assist in training and be required to attend any meetings related to the agency or agencies they audit. In addition, they will be required to attend E-SCARS Steering Committee meetings.

Conclusion

The proposed expansion to the E-SCARS Unit will improve the performance of the LADA as it relates to E-SCARS and will have the concurrent benefit of improving the performance of the partner agencies, ultimately leading to improved service to victims impacted by child abuse and neglect. Additional Paralegals will result in the LADA's ability to audit a greater percentage of SCARs throughout the County. A dedicated, full-time DIC will result in better efficiency, closer oversight, and a more focused approach to the LADA's mission. The additional resources will also result in LADA's ability to provide more frequent and extensive training, both within the office and to E-SCARS partners, resulting in improved performance by all involved agencies.

APPENDIX 6

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Child Abuse & Neglect

Is the diagnosis of physical abuse changed when Child Protective Services consults a Child Abuse Pediatrics subspecialty group as a second opinion?

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ABSTRACT

Objectives: To characterize the changes regarding the diagnosis of physical abuse provided to Child Protective Services (CPS) when CPS asks a Child Abuse Pediatrics (CAP) specialty group for a second opinion and works in concert with that CAP group.
Methods: Subjects were reported to CPS for suspected physical abuse and were first evaluated by a physician without specialized training in Child Abuse Pediatrics (non-CAP physician). Subjects were then referred to the area's only Child Abuse Pediatrics (CAP physician) group, located in a large metropolitan pediatrics center in the United States, for further evaluation. The diagnoses regarding abuse provided by CAP physicians working in concert with CPS were compared to those provided to CPS by other physicians.
Results: Two hundred consecutive patients were included in the study. In 85 (42.5%) cases, non-CAP physicians did not provide a diagnosis regarding abuse, despite initiating the abuse report to CPS or being asked by CPS to evaluate the child for physical abuse. Of the remaining 115 cases, the diagnosis regarding abuse differed between non-CAP physicians and CAP physicians working in concert with CPS in 49 cases (42.6%; $\kappa = .14$; 95% CI, −.02, .29). In 40 of the 49 cases (81.6%), CAP assessments indicated less concern for abuse when compared to non-CAP assessments. Differences in diagnosis were three times more likely in children from a nonurban location (OR 3.24; 95% CI, 1.01, 11.36).
Conclusions: In many cases of possible child physical abuse, non-CAP providers do not provide CPS with a diagnosis regarding abuse despite initiating the abuse investigation or being consulted by CPS for an abuse evaluation. CPS consultation with a CAP specialty group as a second opinion, along with continued information exchange and team collaboration, frequently results in a different diagnosis regarding abuse. Non-CAP providers may not have time, resources, or expertise to provide CPS with appropriate abuse evaluations in all cases.
Practice implications: Though non-CAP providers may appropriately evaluate many cases of physical abuse, the diagnosis regarding abuse provided to CPS may be changed in some cases when CAP physicians are consulted and actively collaborate with CPS investigators. Availability of Child Abuse Pediatrics subspecialty services to investigators is warranted.
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Introduction

Child abuse is a common condition, occurring in approximately 11/1000 children in the United States annually (Department of Health and Human Services, Administration on Children, Youth and Families, 2008). Primary care providers and other physicians without special expertise in child abuse may appropriately evaluate many cases; however, other cases may be more challenging, time consuming, or complex. In these instances, special expertise in and dedication to child abuse may be beneficial. In these cases, a Child Abuse Pediatrician may provide the needed expertise and availability to ensure the best possible outcome for both the child and the family involved in the investigation.

Child Abuse Pediatrics (CAP) is an emerging subspecialty. The American Board of Medical Specialties approved the CAP application for subspecialty status in 2006, and the first subspecialty certification exam will occur in 2009 (American Board of Medical Subspecialties, 2008). Evaluating complicated cases of possible abuse frequently requires an understanding of important and emerging scientific knowledge base of Child Abuse Pediatrics. Studies have addressed the importance of the history provided by caregivers (Hettler & Greenes, 2003), biomechanical analysis of fracture morphology (Pierce, Bertucci, Vogeley, & Moreland, 2004), mechanical and physiological analysis of head injury (Duhaime et al., 1987; Prange, Coats, Duhaime, & Margulies, 2003; Raghupathi, Mehr, Helfaer, & Margulies, 2004) and scientific evidence regarding bruises and burns (Allasio & Fischer, 2005; Committee on Child Abuse and Neglect, American Academy of Pediatrics, 2002; Daria et al., 2004; Drago, 2005; Dunstan, Guildea, Kontos, Kemp, & Sibert, 2002; Feldman, 1992; Maguire, Mann, Sibert, & Kemp, 2005a, 2005b; Maguire, Mann, Sibert, & Kemp, 2005b; Mathew, Ramamohan, & Bennet (1998); Moritz & Henriques, 1947; Spiller et al., 2003; Sugar, Taylor, & Feldman, 1999). These data have increased the ability of physicians to accurately determine the likelihood of abuse in a scientific manner. It is not yet known what, if any, effect Child Abuse Pediatricians with knowledge in these areas may have on investigations conducted by Child Protective Services (CPS).

In the United States, CPS conducts investigations involving alleged child physical abuse. Many of these cases involve medical evaluations and resulting diagnoses regarding abuse. This information may be critical in determining the outcome of CPS abuse investigations. A major function of the CAP subspecialty is to provide Child Protective Services (CPS) with information regarding the diagnosis of physical abuse in children with suspicious injuries; however, this service may not be available in all locations. In these instances, CPS must rely on physicians without specialized training in child abuse to assess the likelihood of abuse in an injured child, even when cases are difficult, complex or time-intensive. Previous studies have documented physicians' mistrust of CPS and lack of willingness to report some cases of child abuse (Flaherty, Jones, & Sege, 2004; Jones et al., 2008). Some physicians may withhold a specific diagnosis regarding abuse in an effort to decrease involvement in an abuse investigation and/or decrease likelihood of receiving a subpoena to testify regarding the diagnosis of abuse. Additionally, some physicians may feel uncomfortable making a diagnosis regarding abuse based solely on information available at the time of the medical evaluation or due to a lack of expertise. As such, physicians may not provide CPS with a diagnosis regarding abuse in some cases. Additionally, the added expertise of CAP physicians, coupled with continual availability to CPS that allows CAP physicians and CPS to work in concert over time on cases of possible physical abuse, may result in changed diagnoses regarding abuse in some cases.

Previous studies have documented challenges in accurately diagnosing physical abuse in younger children. Jenny found that cases of missed abusive head trauma were more common in younger children (Jenny, Hymel, Ritzen, Reinert, & Hay, 1999). In addition, many clinicians fail to consider developmental status of the child, which changes most rapidly and significantly during the first year of life, when assessing for abuse (Anderst, 2008).

Children in rural locations present a unique challenge when the possibility of child abuse arises. Previous research has shown that the diagnosis of abuse differs between dedicated children's hospitals, which are typically located in more populated areas, and general hospitals (Trokel, Waddimba, Griffith, & Sege, 2006). Clinicians providing care to children in rural locations may have less training in pediatrics (Goodman & the Committee on Pediatric Workforce, 2005) and potentially different relationships with families and communities than urban physicians (Shapiro & Longenecker, 2005). Additionally, CPS offices located in rural areas may cover a larger geographic region, have access to fewer physicians trained in pediatrics, and may conduct fewer physical abuse investigations. Obtaining medical assessments regarding abuse may be more difficult for CPS workers in these locations. It is unknown how these factors unique to the physicians in rural locations may affect the diagnoses regarding abuse provided to CPS.

We hypothesized that the diagnoses regarding abuse provided to CPS by non-CAP physicians would differ significantly from those provided by CAP physicians working in concert with CPS, and that, in many instances, non-CAP physicians would offer no information to CPS regarding the diagnosis of abuse. Additionally, we hypothesized that different diagnosis would be more common in children less than 1 year of age than in older children. Lastly, we hypothesized that different diagnoses would be more common in children from rural locations than in children from urban locations.

Methods

The authors abstracted information from a local database involving all patients referred by CPS to a CAP subspecialty group from 11/06 to 6/07. This time period was selected as the CAP clinic opened in mid-2006, and by late 2006, data collection processes were standardized to allow for appropriate information collection. From its inception, the CAP clinic was made available to and advertised to local and regional CPS offices and investigators. In the months following the end of the study period, advertisement of the clinic to the local medical community commenced. Knowledge of the CAP clinic

by other medical providers could result in non-CAP physicians withholding diagnoses in the anticipation that the CAP team would eventually evaluate the case.

The CAP subspecialty group consisted of 3 full-time child abuse pediatricians employed by the Department of Pediatrics at a large metropolitan medical school in the United States. All members of the CAP subspecialty group will be eligible for board certification in the subspecialty when the first qualifying exam is administered in 2009. Through a formal contractual agreement, the Forensic Assessment Center Network (FACN), the CAP subspecialty group is available to CPS workers for medical consultations for cases arising from 26 counties extending more than 200 miles from the CAP clinic. During the study period, CPS conducted approximately 11,750 physical abuse investigations in the region assigned to the CAP subspecialty group. No other formal system exists to provide medical information to CPS in potential physical abuse cases in the area covered by the CAP group. CPS workers, at their discretion, may bring potentially physically abused children to any physician for assessment. The CAP group is available as a first evaluation option, or as a second opinion, based on the discretion of CPS. In the geographic area included in the study, there is no contractual obligation for a physician to provide CPS with a diagnosis regarding abuse, with the only exception being the CAP group.

Study inclusion criteria were children between the ages of 0 and 18, referral to CPS for suspected physical abuse, an initial assessment for abuse by another physician without specialized training in Child Abuse Pediatrics (non-CAP physician), and a second assessment by the CAP team. Cases in which there was no diagnosis provided by the non-CAP physician, and the case was directly referred to the CAP group by other physicians at the same medical school, were excluded. These physicians may have withheld information regarding diagnosis of physical abuse in anticipation of the CAP group evaluation. Cases referred due to concern of neglect or other types of abuse were not considered in this study, and the diagnosis of neglect was not considered in this study.

For the cases in this study, reports of possible physical abuse of a child were made to CPS by either nonmedical personnel (schools, law enforcement, relatives) or non-CAP medical providers. If the report was made by a nonmedical professional, CPS then took the child to a non-CAP medical provider for an abuse evaluation. All non-CAP physicians either initiated a CPS investigation for suspected abuse or were consulted by CPS regarding the possibility of abuse. All non-CAP physician evaluations occurred in clinics, emergency departments, or inpatient settings, and included a physical exam and laboratory and/or radiographic tests as deemed necessary by the non-CAP physician. Documentation of the non-CAP evaluation was then obtained by CPS, including the diagnosis regarding abuse if the non-CAP physician made one. Following this evaluation, CPS consulted the CAP subspecialty group for a second assessment regarding the diagnosis of abuse.

In addition to verbally conferring with CPS, the CAP evaluation included review of the medical information from the previous non-CAP assessment, and at least one of the following: interview and evaluation of the child and interview of the caregivers, photograph review, radiograph review, and/or further testing such as additional radiographs or blood tests. CAP physicians were available for repeated case follow-up with CPS, if needed, and worked in concert with CPS during the investigation process, if further investigation, such as scene investigation and potential witness interview, were necessary. CAP physicians then provided CPS with an assessment that included a diagnosis regarding abuse. CAP physicians reviewed cases individually; however, in cases where the CAP physician felt the diagnosis was not straightforward, all CAP physicians reviewed the case, and the diagnosis of "abuse" was made only if all 3 CAP physicians agreed.

Consultation of the CAP group was at the discretion of CPS, and not all children with allegations of physical abuse in the community were referred to the CAP group. Common reasons for referral to CAP by CPS included: need for medical opinion regarding likelihood of abuse, mechanism(s) and timing of injury, and clarification of medical findings in the case.

At the time of initial CAP consultation, CPS workers provided a case data sheet with child demographics, case information, and specific questions that they wanted the CAP physician to address in the assessment. Data collected included the child's age, location of non-CAP evaluation (urban vs. rural), non-CAP diagnosis regarding abuse, type of injury, and CAP diagnosis regarding abuse. Previous non-CAP assessments from metropolitan areas with a population greater than 100,000 people were classified as urban. All others were classified as rural. There were no dedicated children's hospitals or facilities with significant dedicated pediatric care available in the rural locations that were included in this study.

Non-CAP diagnosis regarding abuse was classified into three categories: abuse, nonabuse, and no opinion. Cases were classified as "no opinion" when the non-CAP physician did not provide a diagnosis regarding abuse to CPS, despite initiating the CPS case or being consulted by CPS regarding possible physical abuse. CPS and CAP physicians jointly determined classification of cases by non-CAP physicians at the time of CAP consultation. CAP assistance in this matter was necessary only when CPS workers did not understand the medical documentation provided by non-CAP physicians. CAP diagnosis regarding abuse was classified as abuse or nonabuse. CAP physicians made the diagnosis of abuse when the preponderance of evidence supported the diagnosis of child abuse, based on the Texas Administrative Code definition (Texas Administrative Code, 2004). All other cases were classified as nonabuse, including those where it was not possible to determine if abuse had occurred. All data was collected at the time of CPS consultation on data collection sheets used locally for the statewide Forensic Assessment Center Network (FACN). This data was entered into a computerized database used for FACN statistics. Data for this study was abstracted from the local database by the authors.

Physical findings concerning for abuse were divided into five primary injury subtypes based on the main injury that resulted in referral: head injury, fracture, burn, bruising, and other. Injuries in the "other" subgroup were typically skin findings that could not be clearly classified as bruises or burns (for example, scars or blisters).

Cases for which the non-CAP physician provided a diagnosis regarding abuse were compared to CAP diagnoses in the same cases. Differences in diagnosis existed when CAP assessment of abuse differed from non-CAP assessment. When a difference

Table 1
Comparison of groups with and without a diagnosis provided to CPS by non-CAP physicians.

Characteristic	Diagnoses provided	No diagnosis provided
Number	115	85
Mean age (*SD*)	2.99 (4.12)	3.36 (3.81)
Rural (%)	18 (15.6)	10 (11.8)
Injuries		
Head (%)	25 (21.7)	10 (11.7)
Fracture (%)*	26 (22.6)	10 (11.7)
Burn (%)*	7 (6.1)	16 (18.8)
Bruise (%)	44 (38.2)	38 (44.7)
Other (%)	13 (11.3)	11 (12.9)

* $p < .05$.

in diagnosis existed, the CAP physician recorded his/her perception of the reason for the difference as one of the following: plausibility of mechanism, additional information gathered by CPS during the investigation, additional information gathered by the CAP physician, or different interpretation of radiographs or tests.

The institutional review board of the University of Texas Health Science Center San Antonio approved this study.

Data analysis

The kappa statistic (κ) for inter-rater reliability was calculated for all cases in which the non-CAP physician offered a diagnosis regarding abuse. κ was also calculated for the 5 primary injury subtypes. Additionally, unadjusted odds ratios (OR) for differing diagnosis based on urban versus nonurban location of non-CAP assessment, and age of the child were calculated. All data were analyzed using SAS version 9.1.

Results

Two hundred consecutive patients meeting inclusion criteria were included in the study, representing approximately 1.7% of all physical abuse cases investigated by CPS in the region during the study period. No cases were direct referrals by other physicians or medical providers. Mean age was 3.15 years (*SD* = 3.99), and median age was 2 years. Specific data on non-CAP physician training was not available for this study; however, some of the specialties of the non-CAP physicians were known and included Emergency Medicine, Pediatric Emergency Medicine, Pediatrics, Family Practice, Neurosurgery, and Orthopedics.

Table 1 compares children given and not given an assessment regarding the diagnosis of abuse by non-CAP physicians. Children with fractures were significantly more likely to be given a diagnosis regarding abuse than children with other injuries by non-CAP physicians. Burns were less likely to be given a diagnosis than other injuries. No other significant differences existed between the two groups.

In 42.5% (85/200) of all cases, non-CAP physicians did not provide CPS with a diagnosis regarding abuse. In those 85 children, CAP physicians working in concert with CPS diagnosed abuse in 27 (31.8%) and nonabuse in the remaining 58 (68.2%). We analyzed the agreement between the CAP physicians working in concert with CPS and non-CAP physicians for the 115 cases in which both the physicians provided a diagnosis regarding abuse (Table 2). No agreement beyond what would be expected by chance was seen ($\kappa = .14$, 95% CI −.02, .29). CAP physicians changed diagnoses provided to CPS in 49/115 (42.6%). The change in 81.6% of these cases was from abuse to nonabuse, whereas the reverse was true in 18.4%. The main reason for disagreement was plausibility of mechanism (87.8% of cases); disagreement in remaining cases was due to additional information gathered during multidisciplinary CAP evaluation or differing interpretation of tests or radiographs. In the analysis by injury subtype, the only injury subtype with significant agreement was head injury (Table 3). No κ was calculated for burns due to low numbers. Of the 115 cases where non-CAP physicians gave a diagnosis regarding abuse, 97 evaluations occurred in urban areas (Table 4). Difference in diagnosis was 3 times more likely to occur in rural locations than in urban areas (OR = 3.24; 95% CI, 1.01, 11.36).

Further characterization of cases with differing diagnosis regarding abuse in head injuries is found in Table 5. All discordant cases involving head injury had a previous diagnosis of abuse by non-CAP physicians. The rationale for the diagnosis of abuse

Table 2
Comparison of diagnoses provided to CPS by non-CAP physicians and CAP physicians working in concert with CPS (overall).

CAP diagnosis	Non-CAP physician diagnosis			
	Abuse (%)	Nonabuse (%)	Total (%)	Kappa (95% CI)
Abuse	50	9	59(51.3)	.14 (−.02, .29)
Nonabuse	40	16	56(48.7)	
Total	90 (78.3)	25 (21.7)	115 (100)	

Table 3
Comparison of diagnoses provided to CPS by non-CAP physicians and CAP physicians working in concert with CPS (by injury).

Injury	Other physician diagnosis, number (%)				
	CAP diagnosis	Abuse	Nonabuse	Total (%)	Kappa (95% CI)
Head injury	Abuse	11	0	11 (44)	.47 (.18, .75)
	Nonabuse	7	7	14 (56)	
	Total	18 (72)	7 (28)	25 (100)	
Fracture	Abuse	8	5	13 (50)	−.15 (−.5, 0.2)
	Nonabuse	10	3	13 (50)	
	Total	18 (69.3)	8 (30.7)	26 (100)	
Burn	Abuse	4	0	4 (57.1)	0 (0, 0)
	Nonabuse	3	0	3 (42.9)	
	Total	7 (100)	0 (0)	7 (100)	
Bruise	Abuse	24	4	28 (63.6)	.05 (−.21, .31)
	Nonabuse	13	3	16 (36.4)	
	Total	37 (84.1)	7 (15.9)	44 (100)	
Other	Abuse	3	0	3 (23.1)	.17 (−.07, .4)
	Nonabuse	7	3	10 (76.9)	
	Total	10 (76.9)	3 (23.1)	13 (100)	

Table 4
Comparison of diagnoses provided to CPS by non-CAP physicians and CAP physicians working in concert with CPS (by location).

Location	Other physician diagnosis				
	CAP diagnosis	Abuse (%)	Nonabuse (%)	Total (%)	Kappa (95% CI)
Urban	Abuse	46	6	52 (53.6)	.2 (.04, .37)
	Nonabuse	31	14	45 (46.4)	
	Total	77 (79.4)	20 (20.6)	97 (100)	
Rural	Abuse	4	3	7 (38.9)	−.21 (−.6, .17)
	Nonabuse	9	2	11 (61.1)	
	Total	13 (72.2)	5 (27.8)	18 (100)	

Table 5
Differing diagnosis of head injury. All cases changed from non-CAP diagnosis of abuse to CAP diagnosis of nonabuse.

Case	Age	Mechanism	Injury	Rationale for non-CAP diagnosis
1[a,c]	11 months	Fell of couch	Linear skull fx, small EDH	Delay in care
2[a,c]	5 weeks	Fell from unfastened car seat on a stroller	Linear skull fx, small EDH	Teen mom
3	6 months	Fell off bed	Linear skull fx	24 h delay
4[a,c]	8 months	Fell off bed	EDH	Delay in care
5[a,c]	6 months	Fell off bed	Linear skull fx	2 day delay
6[a,c]	8 months	Fell while cruising	Linear skull fx	Delay in care
7[a,b,c]	8 months	None	SDH	None

Head CT obtained in all cases. See text for supporting references regarding CAP diagnosis.
[a] Skeletal surveys obtained.
[b] MRI with/without contrast and MRV obtained.
[c] Ophthalmologist exam showed no retinal hemorrhages.

as documented in the medical chart by non-CAP physicians is included in Table 5. Table 6 describes discordant cases involving fractures. None of the subjects with fractures had any examination findings, medical history or family history suggestive of osteogenesis imperfecta (Bishop, Sprigg, & Dalton, 2007; Jenny, 2006). No children had evidence of poor ossification or bone dysplasia on radiographs. Supportive citations for CAP diagnosis in cases of fractures are listed in Table 6.

Of the 115 cases where non-CAP physicians provided a diagnosis regarding abuse, 41 were less than 1 year old. Of the remaining 85 patients, 19 were less than 1 year old. Non-CAP physicians were more likely to provide a diagnosis regarding abuse (OR, 1.92; 95% CI, 1.01, 3.64) in children less than 1 year of age compared to children older than 1 year; however, there was no association between age <1 and agreement with CAP/CPS team diagnosis.

Discussion

According to the US Department of Health and Human Services, there were 3.3 million reports of child maltreatment in 2006 (Department of Health and Human Services, Administration on Children, Youth and Families, 2008). With this large caseload, CPS workers need rapid access to quality medical feedback in cases of possible child physical abuse. However, many physicians are uncomfortable evaluating children who may be victims of abuse (Flaherty et al., 2004). Physicians have

Table 6
Differing diagnosis of fractures.

Case	Age	Mechanism	Injuries	CAP diagnosis	References for diagnosis
1	4 months	6 inch fall	Buckle fx of distal femur	Abuse	Pierce, Bertucci, Vogeley, and Moreland (2004), Helfer, Slovis, and Black (1977), Nimityongskul and Anderson (1987)
2	10 months	Fall from couch	Displaced spiral fx of humerus	Abuse	Pierce, Bertucci, Vogeley, and Moreland (2004), Helfer, Slovis, and Black (1977), Nimityongskul and Anderson (1987), Strait, Siegel, & Shapiro (1995), Kleinman (1998)
3	10 months	Fall from bed	Intertrochanteric fx of femur	Abuse	Pierce, Bertucci, Vogeley, and Moreland (2004), Helfer, Slovis, and Black (1977), Nimityongskul and Anderson (1987), Kleinman (1998), Jones, Feldman, & Bruckner (2004)
4	3 years	Unwitnessed fall	Suprachondylar fx of humerus, three other fx subsequently discovered	Abuse	Jenny (2006), Bishop, Sprigg, & Dalton (2007)
5	8 months (not cruising)	None	Healing transverse ulna fx	Abuse	Pierce, Bertucci, Vogeley, and Moreland (2004)
6	2 years	Fall backwards onto outstretched hand	Suprachondylar humerus fx	Nonabuse	Strait, Siegel, & Shapiro (1995), Kleinman (1998)
7	2 years	Fall	Suprachondylar humerus fx	Nonabuse	Strait, Siegel, & Shapiro (1995), Kleinman (1998)
8	2 years	Fall with twist	Spiral femur fracture	Nonabuse	Pierce, Bertucci, Vogeley, and Moreland (2004), Schwend, Werth, & Johnston (2000)
9	8 months	Fall in arms of caregiver with direct axial load onto femur	Buckle fracture of distal femur	Nonabuse	Pierce, Bertucci, Vogeley, and Moreland (2004)
10	10 years	Fall onto outstretched hand	Buckle fracture of radius	Nonabuse	Pierce, Bertucci, Vogeley, and Moreland (2004)
11	8 months	Caregiver rolled child over with humerus behind back	Oblique fracture of humerus	Nonabuse	Hymel and Jenny (1996)
12	18 months	Fell with twist	Toddler's fracture	Nonabuse	Kleinman (1998)
13	4 months ex-29 week premie	None	Rib fractures (patient had Rickets apparent on plain films)	Nonabuse	Kleinman (1998), Jenny (2006), Bishop, Sprigg, & Dalton (2007)
14	3 years	None	Toddler's fracture	Nonabuse	Kleinman (1998)
15	8 months	Injured in "Jumperoo"	Spiral tibia fracture	Nonabuse	Moineau and Plint (2005)

identified a lack of knowledge about child abuse, negative experiences with CPS, and the additional time required to evaluate suspected abuse as obstacles in these cases (Flaherty et al., 2004).

It is likely that in many, if not most, cases of physical abuse, non-CAP physicians may provide CPS with accurate, easily obtainable diagnoses regarding abuse, or CPS may not even need physician input to assess an abuse allegation. However, in over 40% of the cases referred to the CAP team by CPS, non-CAP physicians did not provide CPS workers with a diagnosis regarding physical abuse even though the physician was the reporter or the physician was asked by CPS to evaluate the child for abuse. This, however, may be the correct course of action if the non-CAP physician feels he/she does not have enough information, time and/or expertise to make such a diagnosis. In many cases, the CPS worker contacted the non-CAP physician to request their opinion regarding the diagnosis of abuse, but this information was not always provided. In instances where the physician does not give a diagnosis regarding abuse and there is no available CAP physician, the CPS worker must decide, despite minimal medical training, the plausibility of abuse or accident causing a child's injury. Potential "triggers" for CAP referral may include cases where non-CAP physicians feel they do not have the time, expertise, and/or willingness to provide continued support and feedback to CPS, cases where scene investigation (such as burns) or further interviews with potential witnesses may significantly affect the diagnosis, cases where practitioners with pediatric training and/or experience are not available, conditions where there is a significant potential for medical conditions mimicking abuse (such as osteogenesis imperfecta), or cases where CPS does not understand the medical information or has further questions regarding the case. Further study into the question of case characteristics that suggest the need for CAP involvement is warranted.

Even when a physician does make a diagnosis regarding abuse, these diagnoses may be based only the information available at that time and little coordination with investigators may limit the consideration of information from the scene investigation, interviews of potential witnesses, and other vital information. In our study, CAP physicians working in concert

with CPS changed over 40% of diagnoses previously provided to CPS by non-CAP physicians. Most of these changes (81.6%) resulted in a lower suspicion of abuse. In 18.4% of cases, the diagnosis was changed from nonabuse to abuse. Although it is not possible to discern specifically how many diagnoses were changed due to the process of continued investigation and CPS/CAP collaboration versus clinical expertise of CAP physicians, most of these changes were due to different interpretations of plausibility of mechanism. The information regarding injury mechanism is usually available to non-CAP physicians when the history is obtained from caregivers; however, the CPS scene investigation and interview process frequently adds information to the proposed mechanism of injury that is not available at the time of the child's medical care. Sometimes this additional information was obtained at the request of the CAP physician. The continued coordination between CPS and CAP, a service that most non-CAP physicians cannot provide due to time and other constraints, ensures consideration of all factors relevant to the child's injury. Additionally, CAP groups may frequently work as a team, consulting one another on difficult cases, and have additional time and access to resources (pediatric subspecialists and social workers, for instance) that non-CAP providers may not have. The process of continued availability to CPS and further evaluation beyond the initial presentation to medical providers may play a significant role in maximizing the potential for an accurate diagnosis regarding abuse.

Different physicians may have different thresholds for determining that abuse was likely the cause of a child's condition. For some physicians, the diagnosis of abuse is made if it is the *only* possible cause of the condition. For others, abuse is diagnosed if it is the *most likely* cause. These differing thresholds, in turn, may affect opinions provided to CPS. In our study, the majority of the changed diagnoses could be considered "overcalls" of abuse. However, as previously noted, non-CAP physicians making these diagnoses may frequently have only part of the necessary information. Reporting a suspicious injury that is later clarified as attributable to nonabusive causes may be preferable to missing abuse, provided that a CAP team is available to work in tandem with CPS to fully evaluate the case.

Given the increased odds of a changed diagnosis in cases originating from rural locations, CPS workers in rural locations may particularly benefit from the availability of a CAP group. Fewer physicians with pediatric training are available in rural locations (Goodman & the Committee on Pediatric Workforce, 2005). Additionally, physicians practicing in rural locations may have closer relationships with families and the community (Shapiro & Longenecker, 2005) which may impact decision making in possible abuse cases. We believe that our findings are due to a paucity of pediatric-trained physicians in the rural areas of the study's catchment area. Further investigation regarding how these unique characteristics of rural medicine affect assessments of potential child abuse is warranted.

Our study showed that children younger than 1 year of age were more likely to be given a diagnosis regarding abuse by non-CAP physicians. Physicians may be more confident in assessing the likelihood of abuse in very young children. Despite a greater tendency to provide a diagnosis in this younger age group, differences in diagnosis between the non-CAP and CAP physicians occurred at the same rate as in the older age groups.

Non-CAP physicians were less likely to provide diagnoses regarding abuse to CPS in children with a burn. Burns, more so than other injuries, require in-home investigation, such as determining water temperatures and the photographing the scene. Non-CAP physicians may have felt that they did not have adequate information to make diagnoses regarding abuse. Conversely, non-CAP physicians were more likely to provide CPS with diagnoses regarding abuse in children with fractures. However, agreement between the CAP/CPS collaborative team and non-CAP physicians was low for children with fractures. At least some of the lack of agreement may be attributable to further characterization of the mechanisms of injury, as discovered in the CAP/CPS investigative process, and knowledge of the current understanding of likely resulting fractures in children, as summarized in the provided references (Table 6).

Head injuries provide examples of the possible inappropriate use of perceived risk factors in making the diagnosis of abuse (Table 5). A diagnosis based on perceived risk factors for abuse, as documented by non-CAP physicians in the medical chart in these cases, may differ significantly from a diagnosis based on analysis of compatibility of the injury with the reported mechanism, taken in concert with details from a CPS investigation. Six of the seven cases of differing diagnosis involved impact injuries (linear parietal skull fractures and/or epidural hemorrhages). Short falls can cause these types of injuries (Choux, Grisoli, & Peragut, 1975; Helfer, Slovis, & Black, 1977; Jonker & Oosterhuis, 1975; Nimityongskul & Anderson, 1987). In five of the cases, non-CAP physicians cited a "delay in seeking care" as their main reason for diagnosis of abuse. In four of those cases, caregivers reported a history of a short fall with no subsequent ill symptoms seen in the child. Medical attention was sought at a later time when soft tissue swelling was noted on the child's head at the site of impact. One of these cases was supported by videotaped evidence discovered during the scene investigation conducted a week after the child's hospitalization. The remaining two cases consisted of a child with a growing epidural hemorrhage after a short fall and a child with a subdural hematoma with no history of trauma. The child with the subdural hematoma was diagnosed as "abused" by a neurosurgeon. Subsequent CAP evaluation, including an MRI with contrast and an MRV, noted a subdural hematoma with a neomembrane and a vascular malformation. Vascular malformations are known causes of subdural hematomas (Meyer-Heim & Boltshauser, 2003), and neomembranes can cause persistent bleeding into a subdural hematoma (Yamashima, 2000).

This study has several limitations. It is retrospective in design. It was impossible to know the full extent of information available to non-CAP physicians, as their assessments were evaluated based on information they provided to CPS. Non-CAP physicians did not have the benefit of review of the information gathered during the investigative process. As such, the data from this study should not be interpreted as a direct statistical comparison of accuracy of diagnoses between CAP versus non-CAP physicians; rather, this study supports continued evaluation of potential abuse cases and collaboration with CPS by physicians with subspecialty training. There was an inherent selection bias to the study, as a report had to be made to CPS and CPS had to consult the CAP group for children to be included in the study. This may have resulted in a higher percentage

of cases without a diagnosis from non-CAP physicians and a higher rate of different diagnosis. However, the main focus of the study was the impact of CAP availability on information provided to CPS. Thus, though the cases in this study were a select group of children at risk for abuse, the data obtained from their evaluation supports a need for CAP availability. Specific data regarding years of experience of type of training of non-CAP physicians was not available for this study. Future studies are needed to examine the effect of physician characteristics on abuse assessments.

There is a lack of an accepted "gold standard" in child abuse cases. Other fields, such as radiology and psychiatry also lack "gold standards" and diagnosis is based upon accepted standards, individual interpretation, and/or best available scientific evidence, as was cited in this study. It is highly unlikely that the non-CAP physicians in this study withheld diagnoses in anticipation of CPS consulting CAP, as the CAP consultation service had not been advertised and area physicians were likely unaware of these services at the time of our study. This is supported by the fact that none of the referrals to the CAP clinic without diagnoses were made by physicians; all were made by CPS. Discordant diagnosis among CAP physicians may exist (Lindberg, Lindsell, & Shapiro, 2008); however, it may be minimal when CAP physicians have access to and participate in the CPS investigative process, as in this study.

Conclusions

In many cases of possible child physical abuse, non-CAP providers do not provide CPS with a diagnosis regarding abuse despite initiating the abuse investigation or being consulted by CPS for an abuse evaluation. CPS consultation with a CAP specialty group as a second opinion, along with continued information exchange and team collaboration, frequently results in a different diagnosis regarding abuse. Non-CAP providers may not have time, resources, or expertise to provide CPS with appropriate abuse evaluations in all cases.

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APPENDIX 7

WRMA

Walter R. McDonald & Associates, Inc.

Los Angeles County
Blue Ribbon Commission for Child Protection

SUPPLEMENTAL REPORT ON RECOMMENDATIONS

(PHASE I OF WRMA CONTRACT)

Prepared for:
Los Angeles County
Blue Ribbon Commission on Child Protection

Prepared by:
Walter R. McDonald & Associates, Inc.
2495 Natomas Park Drive, Suite 575
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December 12, 2013

Los Angeles County
Blue Ribbon Commission for Child Protection

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December 12, 2013

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I. INTRODUCTION

In August 2013 Walter R. McDonald & Associates, Inc. (WRMA) submitted a proposal to the Los Angeles County Blue Ribbon Commission on Child Protection to perform tasks that were outlined in a Statement of Work that was issued by the Commission. One of the Tasks involved a review of documents to identify recommendations that dealt with Child Safety. In our proposal we posed five questions to be answered as the result of a review of the recommendations that were catalogued and classified on a database that WRMA developed. Based on the work done to date, the two questions that remain unanswered have to do with an evaluation of the status of the recommendations, which was not within the scope of this task. Those questions are:

- What recommendations have been implemented successfully and unsuccessfully? Why have certain recommendation not been successfully implemented?
- What recommendations have not been implemented? Why?

Of the original five questions, Commission staff and WRMA staff agreed that three of the questions are still relevant to the scope of this work. This supplemental report presents the results of our answers to the three remaining questions:

- Which of these recommendations are research-based best practices that are relevant, appropriate, and implementable for LA County?
- What recommendations are related to child safety?
- How many recommendations address collaboration/cooperation/coordination of DCFS and other responsible agencies?

II. RESULTS OF THE DATABASE REVIEW FOR RESEARCH-BASED RECOMMENDATIONS BACKGROUND

The following section details which recommendations are identified as researched-based best practices that are relevant, appropriate, and implementable for LA County. First, the terms relevant to this question; research based, evidence based, and best practices were reviewed and then the terms were used to search the recommendations database. Finally, this section presents results of these searches, and patterns in the recommendations that pertain to this question, as well as the implications of these findings.

DEFINITION OF TERMS

Support for how well a program or practice works can be 'evidence' based and 'non-evidence' based. Among those that are evidence-based, the amount of evidence for a program may vary, but is rooted in science. Among programs that have non-evidence based support, the evidence is subjective, or personal, such as being popular among staff, liked by clients, or was implemented because the program was well funded at the time. Research-based and best practices refer exclusively to programs that are evidence based.

With respect to evidence based practice, The California Evidence-Based Clearinghouse for Child Welfare (CEBC) is a central, comprehensive clearinghouse for child welfare practice in the state of California. According to their website, CEBC "provide[s] child welfare professionals with easy access to vital information about selected child welfare related programs. The primary task of the CEBC is to inform the child welfare community about the research evidence for programs being used or marketed in California. The CEBC also lists programs that may be less well-known in California, but were recommended by the Topic Expert for that Topic Area."

The CEBC defines evidence-based child welfare practice as meeting the following criteria: 1) that the child welfare practice is based on the best research evidence, 2) the child welfare practice is based on the best clinical practice, and 3) the child welfare practice is consistent with family/client values.

Child welfare practice that is evidence based can be further broken down into sub categories of evidence that are used to support it. Below, the terms evidence-based, research-based, and promising practice are used to identify the highest, middle range, and lowest strata of evidence-based support. These terms are not comprehensive, are regionalized, and specific to the discipline and/or organization in which they are used, so both definitions and terms will vary across location and time. These are provided – as an example – of definitions formulated at the state level, based on a report produced by the University of Washington's Evidence Based Practice Institute.

1) HIGHEST LEVEL OF EVIDENCE – evidence-based practice – this program or practice has been tested with multiple randomized or statistically controlled evaluations, or one very large evaluation where the evidence supports sustained improvement in one of the following domains; child abuse, neglect, out of home placement, crime, children's mental health, education, employment.

2) MEDIUM LEVEL OF EVIDENCE – research-based practice – this program or practice has been tested with a single medium to small scale randomized or statistically controlled evaluation demonstrating sustained desirable outcomes in the above mentioned domains or where the weight of the evidence from a systematic review supports sustained improvement in the domains, but does not meet the criteria for evidence based practice.

3) LOW LEVEL OF EVIDENCE – promising practice (sometimes called best practices) – this program or practice, based on some statistical analysis or theory shows the potential for meeting the evidence-based or research-based criteria.

In considering these terms, the resources and definitions from the CEBC may be useful for Los Angeles County DCFS. It may help locate evidence for current or planned programs, and may help in formulating standards of evidence-based programs and practice. Most importantly, it may help define terms used to communicate about evidence-based practice. A common understanding of key concepts and terms is central to communication about evidence-based practice and programs, and thus to their consideration and implementation.

RESULTS

In a search of the recommendations, there were 13 recommendations that included the use of the term 'evidence', while there were 2 recommendations that included the word 'research.' Three of the recommendations contained the word 'promis' (short for promise or promising) and 17 contained the word 'best.' In a review of these recommendations, none referred to a specific program that was also indicated to have empirical support. This search was augmented by a manual review of approximately 600 of the 733 recommendations. All of these recommendations, based solely on the text of the recommendations themselves appear, to varying degrees, to be relevant to child welfare practice and programs.

However, in making these recommendations, which sometimes called for a wider roll out of programs, no evidence was specifically cited. A few recommendations *referenced* programs that have had research or evaluations conducted, but they may have been conducted by other organizations or in other jurisdictions. Those general references include, Alcoholic Anonymous, therapeutic foster care, drug courts, and trauma-focused therapy, or trauma systems therapy. In one recommendation pertaining to trauma systems therapy, it is implied that this program reached the recommendation level through word-of-mouth, rather than an exploration for evidence based interventions to address trauma. Further, the recommendations that mentioned these programs did not contain enough information about implementation or the context and other factors to make a determination about the appropriateness of the recommendation or assess if it could realistically be implemented.

Another set of recommendations specified seeking out, locating, identifying or exploring existing evidence in a particular service or topic area. These included; mental health services, specifically recommendations that pertain to the Katie A. Lawsuit; screening; the use of evidence and crimes; treatment models; core court services; relative placement; transition age youth, including AWOL and sex trafficking; E-SCAR; home visitation; housing programs; and lower caseloads/workloads for social workers and DCFS staff.

Any recommendation that is intended to add or modify a program or practice should be based, at least in part, on each of the following components:

1) Relevant data from DCFS about the client/target population;
2) Current DCFS policy (not just one page or section, but all relevant sections from the full body of DCFS policy for Los Angeles County);
3) Current Laws (County, State, and Federal, etc.);
4) Research and Evaluation that has been conducted in LA County;
5) Research and Evaluation conducted in other jurisdictions (surrounding counties, the five largest cities, California, other counties and states in the US);
6) Research in other related fields;
7) The intent of the recommendation (define the intended impact of the recommendation and outcome);
8) The extent to which the recommendation is feasible and can be implemented;
9) The extent to which the impact of the recommendation can be measured.

Research should be considered as part of a larger picture of the foundational factors listed above, as well as these further considerations:

1) Funding (is the funding ongoing, time limited or closed ended)
2) Duration (will the change be permanent or time limited)
3) Engagement (is the program used/will it be used by the target population, or implemented by the staff it is intended for)

In short, research should be considered for any recommendation that may alter or initiate a practice or program. Potentially, any recommendation may be guided by research, depending upon the specific program or practice in question, or the proposed modification or change. When developing recommendations research and evaluation findings should be considered in framing the recommendation.

CONCLUSION

This section reviewed which recommendations were researched-based best practices that were identified in the documents that were reviewed. To determine which recommended programs and practices are supported by evidence would be the first step in answering this question. None of the recommendations reviewed mentioned evidentiary support. Generally, the program or practice named was too broad or general to make this determination, or not enough information was provided about the specific program or practice behind the recommendation to search for evidentiary support elsewhere. However, this is a good first step in building an understanding of evidence-based recommendations. The recommendations provide a sketch of the areas, as outlined above, in which specific recommendations mention exploring for evidence or using evidence based practice or programs. Thus they provide an outline of the program areas in which planning for research and evaluation might commence.

III. RESULTS OF THE DATABASE REVIEW FOR SPECIFIC CHILD-SAFETY RECOMMENDATIONS

BACKGROUND

This section reviews recommendations that pertain to child safety and defines safety. The section also outlines the steps taken to select records that pertained to safety, describes those records and their implications. Safety is of utmost importance in child protection because it means, simply, deciding if a child is in danger of being harmed or maltreated right now. (This definition is based on the Breakthrough Series Collaborative Final Report 2009).

ALL RECOMMENDATIONS THAT PERTAIN TO SAFETY

There are a number of ways to count recommendations that pertain to safety, ranging from a broad conceptual definition to a more focused definition based solely on the categories provided that contain that specific term. For this section of the report, reviewers compiled those recommendations that pertain to child safety where the word safety is used as a category. This includes recommendations where the focus is safety assessment/planning, or the child outcome is 'safety.'

SAFETY ASSESSMENT/PLANNING

The program area of safety assessment and planning was associated with 93 of the 733 recommendations, or about 13% of the recommendations. Twenty two of these pertained to law enforcement, the single largest sub-category within safety assessment/planning that was identified during a preliminary analysis. Many of the most illustrative examples of safety appear in the section from the June 11, 2013 report from the Auditor Controller.

The recommendations from the 2013 Audit Controller's report pertained almost exclusively to system-wide safety assessment and planning. This includes establishing a county level entity, convening a child wellness workgroup, convening task forces, reporting on protocols, conducting independent audits, and establishing new data systems to enhance safety. A number of examples of the recommendations that resulted from that report are as follows:

1)	Identify a single, existing County entity to be responsible for compiling data related to child safety indicators and reporting to the Board. Include key child wellness indicators and a reporting protocol.
2)	Provide daily numbers regarding the children and youth who arrive at the Emergency Response Command Post (ERCP), and provide a list of actions taken for any youth who leaves the premises. In addition, develop an implementation plan to overhaul the ERCP unit and processes
3)	Convene a task force to address the issue of sex trafficking of minors within the foster care system. Provide background information, current barriers, best practices, and recommendations.
4)	Provide a plan to ensure the safe placement of children over the age of 10 coming into the ERCP.
5)	Report on protocols to cross-reference and cross-report the addresses of registered sex offenders who reside with children. DCFS to issue monthly reminders to Kin GAP legal guardians to request verification from the Megan's law website.
6)	Compile and report back on vital Los Angeles County child death statistics from 1990 to 2010.

7)	Include in the independent audit of Child Protection Safety Net, a review and analysis of the role, responsibilities, and impact of the Children's Special investigation Unit.
8)	Report back on DCFS system demographics and fatalities in the past three years. Identify trends/issues to determine how these may contribute to deficiencies in existing policies related to identifying, assigning, reporting, and monitoring cases (as requested on 7/28/2009).
9)	Prepare report on status of Probation Case Management System (PCMS) to track AWOL and those who are on bench warrant status. In addition, the CSIU is to include results of a child death investigation under jurisdiction of DCFS, and indicate any contact with Probation or a law enforcement agency.
10)	Facilitate multi-agency inspections of postpartum recovery homes; draft a proposed ordinance for consideration and recommendation to eliminate use. Identify additional funding to assist inspectors.
11)	In response to item 2 from 8/4/2009, direct DCFS to begin the process of implementing the enhanced safe measures automated alerts as indicated in the CEO report.

SAFETY OUTCOME

Within this category a total of 237 records contained a child outcome of safety. This is 32% of all recommendations in the database. Of these, 13 recommendations reflect that they were implemented, 3 are pending and the remainder, 218 recommendations, has an implementation status that is unknown, while 3 did not have a value for this item.

Safety was often cited generically as a concern in these recommendations, or in conjunction with permanency and well-being. In some recommendations, safety was indicated as it is one of the three prime outcomes for children. Other broad recommendations that include child safety outcomes pertained to enhancing prevention efforts, family preservation (while maintaining safety), making calls to the Child Protection Hotline, investigating physical abuse, the courts, law enforcement and child fatalities.

Safety recommendations that pertained to the court system, procedures, collaboration or in some other way to the court were the most common subject of recommendations pertaining to safety. A full 57 recommendations referenced the courts or roughly one in four safety outcome recommendations.

Below is a list of three potential, more specific categories within the court recommendations that pertain to safety:

1) Compliance with legislation such as the Indian Child Welfare Act (ICWA), as they pertain to maintaining children safely in their homes.
2) Compliance with safety rules and regulations for foster homes, service providers, and in home care; securing toxic or dangerous items in the home, current authorization for medications, and criminal background checks for adults in the home.
3) Information sharing among courts, and involvement of youth and the community in the court system.

Finally, worth mentioning is the fact that sixteen of the recommendations concerned child fatalities. They included reviews of child deaths during a certain period, a review of a sample of child deaths (included specific, high profile cases), as well as procedures for responding to child fatalities. There were a number of additional recommendations that pertain to preventing fatalities among younger children, including sleeping deaths and mortality associated with prenatal drug and alcohol abuse. There were ten recommendations that pertained to hospitals and some of these were protocols specifically to address fatalities resulting to young children and infants or resulting from substance abuse.

CONCLUSION

A large proportion of recommendations pertain to safety. These recommendations often pertain to broad, system-wide modifications that could impact programs and practice across the County. Many recommendations begin to explore the question: will ending child morbidity and mortality require small practice related changes, or broad system level changes, or perhaps both. As DCFS continues to incorporate and synthesize recommendations that pertain to safety it may be worthwhile to begin to categorize recommendations along these lines.

It may also be beneficial to identify and categorize recommendations based on their level of intervention. Meaning those that are at the practice level could form one end of the spectrum, while those that are system wide could be at the other. Then they could be sorted by category and a hierarchy or flow could result. This would have two benefits. First, it would allow one to see the practice flow of the recommendation (as opposed to the conceptual flow outlined in the first question) meaning one could see a flow from county level down to the worker level, and second; it would allow one to eliminate duplicative recommendations as they would be more prominently organized both by practice area and level of intervention.. For example, the first recommendation from the Auditor Controller's report "Identify a single, existing County entity to be responsible for compiling data related to child safety indicators and reporting to the Board. Include key child wellness indicators and a reporting protocol." is very similar to the recommendation regarding *Performance Counts! Framework (*http://performancecounts.lacounty.gov/) but it is not clear that these recommendations were known to their respective authors.

IV. RESULTS OF THE DATABASE REVIEW FOR RECOMMENDATIONS ON COLLABORATION/COOPERATION/ COORDINATION OF DCFS AND OTHER RESPONSIBLE AGENCIES

BACKGROUND

This section reviews recommendations that address collaboration/cooperation/ coordination between DCFS and other responsible agencies and reviews the recommendations that focused on organization, inter-agency, or resources/collaboration. Issues related to counting this type of recommendation are noted, as appropriate.

ALL RECOMMENDATIONS THAT PERTAIN TO COLLABORATION

In order to count the recommendations in the database that pertain to collaboration, cooperation, and coordination between DCFS with other responsible agencies, the most relevant, broad categories that pertain to this area were identified by selecting the recommendation focus categories of 1) organization, 2) interagency, and 3) resources/collaboration.

ORGANIZATION

Organization was included as a search category because interagency collaboration and resources are organizational concerns, and thus should be considered in light of organizational recommendations. "Organization" was defined as recommendations that deal with an aspect of the management of the organization such as flattening the management structure, increasing the management span of control, etc. A total of 143 recommendations pertained to organization, 20% of the 733 total recommendations. However, only a 35% of these recommendations pertain to collaboration with other agencies. Future analyses may look at this subset of recommendations. Manual reviews of these recommendations indicate that a substantial proportion of the recommendations about collaboration among many agencies such as medical, mental health, law enforcement and DCFS rather than collaboration between just DCFS and an identified other agency.

INTERAGENCY

The interagency focus category was defined as recommendations that 'involve action by more than one county agency/department.' A total of 259 recommendations pertained to interagency. This is 35% of the 733 total recommendations.

Interagency focus may be broken down into more specific categories. There are those recommendations that pertain to a single organization outside of DCFS, and those that pertain to more than one. Further, there are sets of recommendations that pertain to each of the following; information sharing, service integration, policy, program evaluation, and service monitoring.

To illustrate, we present the following as an example of a DCFS interagency recommendation pertaining to a single agency: "Adopt a policy of transparency and inclusion of stakeholders in strategic planning, data sharing, and decision making." . In the above example, that organization is juvenile probation. Though not stated in the recommendation, it is in the context of a juvenile justice report.

Then are other interagency recommendations that pertain to more than one agency outside of DCFS such as:

"The Board of Supervisors should require the Department of Human Resources, in coordination with the Department of Children and Family Services, the Department of public Social Services, the Chief Executive Officer, the Probation Department, and other applicable County departments and agencies to develop a mechanism to identify "at-risk"

youth to participate in the Career Development Intern Program and the Student Worker Program."

Another example of an interagency recommendation that pertains to more than one outside agency, but the agency named is not specified:

"Direct the Chief Executive Office and clusters to leverage available funds by developing partnerships with the community. The county should enhance prevention efforts thereby ensuring the health and well-being of children and families. Services should be client focused with feedback from clients." In this example 'partnerships with the community' leaves open both the number of agencies or organizations and also the types of agencies and organizations however; the context of the report does not clarify these issues.

Due to the large proportion of recommendations with an interagency focus multiple ways to categorize them and interpret them can be devised. Perhaps the most useful way to categorize and examine them will be to organize them according to outside agency. This will allow for a survey of the breadth of interagency collaboration set forth in the recommendations, and will further allow for identification of related recommendations including: by program, topical area, and to eliminate redundant recommendations.

RESOURCES/COLLABORATION

This focus category was defined as recommendations that deal with the need for enhanced services, service expansion or interagency collaboration. Within this category a total of 203 recommendations pertained to resources/collaboration, 28% of the 733 total recommendations. Due to the full definition of the recommendations in this classification, "or interagency collaboration" it is possible that a number of these recommendations overlap with the "interagency" classification outlined above.

A number of these recommendations have to do with resource management. Some pertain to the management of internal resources, while others refer to leveraging resources to augment a shortage. Below are two examples of resources/collaboration recommendations. The first is an example of an internally focused recommendation regarding resources, while the second is focused on resources outside of DCFS.

Example 1: (Internally-focused recommendation):"To ensure that child abuse/neglect allegations receive timely resolutions, the department should: Continue to monitor the status of its investigations backlog, but revise its policies and performance measures to no longer define the backlog as investigations over 60 days old. Rather, emphasize completing investigations within 30 days; and Assess whether it needs to permanently allocate more resources to investigate allegations of child abuse and neglect."

Example 2: (Externally-focused recommendation) "The creation of a Resource Management Process to improve the identification and matching of client needs and strengths with existing and emerging clinical services and placement options."

Example 3: (Mixed Internal and External) "To the extent permitted by law, DCFS, DHS, DMH, and DPH should provide skilled healthcare professionals access to a youth's healthcare information regardless of the department in which the information was originally obtained. However, such access should be limited to those personnel who have been provided confidential user names and passwords…"

As was the case in examining the interagency recommendations, it may be useful to create a sort to organize these recommendations by outside agency, as well as to sort them by distinguishing between an internal, external, and a mixed focus.

SUMMARY

Approximately 35% (around 260) of the recommendations pertained in some way to interagency collaboration. There are several ways to organize and understand these recommendations; however additional reviews and sort criteria would need to be developed. One approach would be to group the recommendations according to agency, and by their focus. This would allow for identification of the breadth of agencies involved in these recommendations, as well as to reduce duplication of recommendations. Another approach would be to organize the recommendations into sub-categories that would include timely subjects such as workforce or staffing. With additional sort criteria defined additional cross-tabulations would be possible, and could be tailored based on the topic that is relevant or of interest at the time of the query.

V. SUMMARY AND CONCLUSIONS

This supplemental report has attempted to answer three questions posed in the original WRMA proposal to the Los Angeles Blue Ribbon Commission.

- Which of these recommendations are research-based best practices that are relevant, appropriate, and implementable for LA County?
- What recommendations are related to child safety?
- How many recommendations address collaboration/cooperation/coordination of DCFS and other responsible agencies?

Research-Based Best Practice

It was anticipated that some of the recommendations that had been made to the County between 2008 and 2013 would be research-based best practice and that an exploration of them would be useful to the Commission. Based on our analysis, we were unable to determine that any of the recommendations contained in the documents reviewed were research based, given a social service definition of research based. Few of the recommendations, less than .02%, referenced "research" or "evidence" and less than .02% of the recommendations referenced "promise" or "best" practice. A few recommendations referenced research or evaluations that had been conducted by other organizations or in other jurisdictions. The lack of any significant number of research-based recommendations on best practice could mean that documents containing Los Angeles County-based research activities or recommendations were not included in the documents reviewed for this task. It could also indicate that the document authoring entities, for example The Commission for Children and Families, the ICAN Child Death Review Team or the Civil Grand Jury, etc. may not be constituted to conduct classic evidence-based child welfare research upon which to make recommendations.

Our review of this area produced suggested areas for the Commission's consideration in terms of what components research-based recommendation should be based on as well as funding, duration and engagement considerations.

Child Safety

The recommendations that dealt with child safety came from the Program Category of "Safety Assessment/Planning" (13% of the recommendations) as well as the Child Outcome factor of "Child Safety" (32% of all the recommendations.) Clearly, the documents that were reviewed from the last five years deal with child safety issues both in terms of child outcomes as well as strengthening prevention efforts. It is interesting to note the large number of recommendations (one in four dealing with child safety) involved references to the juvenile court in the areas of maintaining children safely in their homes and information sharing. This area could benefit from additional exploration.

<u>Interagency Collaboration/Cooperation and Coordination</u>

Again, as with Child Safety, the subject of Interagency Collaboration/Cooperation and Coordination was recognized in the recommendations as an area of high interest. 35% of

the recommendations dealt with collaboration and cooperation activities involving more than one county department or agency. The recommendations involve 1:1 collaboration as well as to one-to-many coordination/collaboration and deal with both strengthened collaboration within an agency as well as externally with other county agencies and community partners. The subjects of this interagency collaboration range from information sharing, service integration, service monitoring to policy/program evaluation. The recommendations range from directly identifying specific departments to collaborate to identifying an entity, such as the Chief Executive Office, to orchestrate and oversee the interagency collaboration.

Another area for collaboration was enhanced services aimed at resource collaboration. For example 28% of the total number of recommendations mentioned resource collaboration in the context of resource management and leveraging resources to augment services. This would also involve revenue maximization through sharing resource pools to maximize resources and services. Addition exploration of this area might be beneficial to the Commission to perhaps group the recommendations by agency as well as programmatically in order to rank the most prominent areas for collaboration and resource sharing.

In conclusion the review of the recommendations in the database did not yield many results in terms of the recommendations being research-based in best practice. The efficacy of future recommendations would definitely be enhanced if the person or entity making the recommendation could develop them based on evidence and research that is relevant to Los Angeles County. As would be anticipated in a review of the documents that yielded the recommendations, a number of them dealt with various aspects of child safety in terms of both outcomes and prevention. It is interesting to note the emphasis on the involvement of the juvenile court in safely maintaining children in their own homes. Finally, as in other areas of our review, a recurring theme is the need for interagency information sharing and collaboration to strengthen and streamline service delivery and possibly reduce duplication among those agencies that serve children and families.

WRMA

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ENDNOTES

[1] To guide its work and fulfill its mandate, the Commission approved the following mission statement on October 18, 2013:

> The Blue Ribbon Commission, pursuant to the Board of Supervisors' motion approved on June 25, 2013, believes that the children of Los Angeles County have a right to grow up free from abuse and neglect. The Commission further believes that abused or neglected children have a right to be protected against further injury. Towards these ends, children and families should be supported so that all children are ultimately able to reach their full potential. To ensure these rights and improve safety for children, as measured by reduced serious injuries due to abuse and neglect, less recurrence of maltreatment and fewer child fatalities, the Commission will focus on systemic change and comprehensive countywide approaches that extend beyond DCFS to include Public Health, Health Services, Mental Health, the Sheriff, the Medical Examiner, First Five and other agencies and organizations that may later be identified; and the various memoranda of understanding involved. The Commission will identify strategies that reflect the broad countywide responsibility for welfare and safety and ensure accountability from entities ranging from the Board of Supervisors to front line practitioners.

[2]Child Welfare League of America Practice Areas: Child Welfare Standards of Excellence Caseload Standards. CDSS SB2030 Child Welfare Services Workload Study: Final Report.

[3] Child fatality rates differ in different parts of the County. For example, among those with a prior DCFS history, 26% of the fatalities were children in SPA 6, and 15% were in SPA 8. 2012 and 2013 SPA 6 and SPA 8 child fatality rates are particularly high contributing significantly to the number of child fatalities countywide. From 2012 to 2013 child fatalities with prior DCFS history doubled in SPA 2.

[4] For example, the vision statement for Allegheny County's Department of Human Services (DHS) reads: "To create an accessible, culturally competent, integrated and comprehensive human services system that ensures individually tailored, seamless and holistic services to Allegheny County residents, in particular, the county's vulnerable populations." Further, DHS has developed a practice model that ensures "consistency and coordination not only across DHS but also across the network of partnering organizations that comprise our public human service system." http://www.alleghenycounty.us/dhs/ai/practice_model.aspx

A second example is the mission statement of the Franklin County Children's Services in Ohio, which highlights the fundamental importance of a partnership approach which includes government, families, and communities: "Through collaboration with families and their communities, we advocate for the safety, permanency and well-being of each child we serve in a manner that honors family and culture." Flowing from this, they articulate clear Guiding Principles, which include:

> **We Value Partnerships**
>
> - Families have the right to be a part of the decision-making team
> - Casework is the most important function of the agency team
> - Families, communities and government share the responsibility to keep children safe.

https://www.franklincountyohio.gov/children_services/about-us/mission.cfm

[5] Letter from LA County Commission for Children and Families to the Board of Supervisors. August 4, 2008. P.3.

[6] Los Angeles County has some exemplary programs that have masterfully integrated services across departments, including outstanding programs where multiple County departments work together with community nonprofits and philanthropy to provide integrated services for children and their families. These are proof that an integrated system can work. For example, UCLA's Stuart House and the Violence Intervention Program at LAC+USC Medical Center each have created child-oriented settings where key County personnel are co-located to streamline services and enhance investigations. The Inter-Agency Council on Child Abuse and Neglect (ICAN) established one of the first inter-agency death review panels. All three are national models of public-private partnerships that have been replicated around the country.

[7] While all Commissioners voted to support the functions of such an office, three believed that the functions could be performed by an existing County entity, such as the CEO's Service Integration Branch, the Commission for Children and Families, ICAN, or through reorganizing the existing clusters.

[8] However, E-SCARS has limitations. Violations occurring outside of the LA County system are not tracked. For example, consider a family who moves to Los Angeles and has a history of child abuse and involvement with the

child protection system in San Bernardino County. When a report is made of suspected abuse in LA County and the DCFS worker checks the family's past history through E-SCARS, the San Bernardino information is not available because the E-SCARS data only pertains to LA County. Abusers who go from county to county can evade detection and appear to have a clean record.

[9] In addition, statistics compiled by the DA's Office indicate substantial variation in the percentage of SCARs that continue on to criminal investigations: in 2013, one law enforcement agency suspected that a crime was committed in 40% of their cases, while 10 law enforcement agencies suspected that a crime occurred in less than 10% of their cases. District Attorney's Office *Law Enforcement Agencies on E-SCARS 2013 Summary Report*. The DA's Office can play an important role in analyzing reasons for these disparities and publicizing these statistics, if appropriate. The Office also should intervene and make an inquiry when E-SCARS flags a case in which there is a disagreement in post-investigation conclusions between DCFS and law enforcement.

[10] For example, a survey conducted by the DA's Office revealed that law enforcement agencies have varying methods of retrieving and responding to SCARs submitted by DCFS. Only 35% of the agencies receive their SCARs via email notification, while the other 65% receive them via fax. In many cases, these SCARs are not reviewed for hours – or sometimes for days. Thus, across LA County, there can be significant delays in opening SCARs. The survey results also indicated that: out of the 65% that receive SCARs via fax, only 28% are checking the fax machine constantly (24/7) for a SCAR; only 37% of the law enforcement agencies have someone to oversee E-SCARS daily to ensure prompt responses and appropriate investigative action; 52% have weekly oversight; 76% of the law enforcement agencies respond to every SCAR received from DCFS, while the other 24% only respond to those where physical injury, sexual abuse, and/or child endangerment is mentioned; only 50% of the law enforcement agencies cross-report all allegations to DCFS, while 30% report suspected crimes, and the remaining 20% defer to the discretion of the responding officer; and, if cost were no issue, 74% of the law enforcement agencies would like to receive SCAR notifications electronically through the Justice Data Interface Controller (JDIC), which is the most effective method. June 4, 2010, Letter from District Attorney Steve Cooley to the Board of Supervisors on Electronic Suspected Child Abuse Report System, Attachments B-F & H. JDIC is a regional law enforcement data communications system networked throughout the County. JDIC links 87 criminal justice facilities within LA County. Along with LASD and other local police agencies, JDIC also provides services to the District Attorney, the Probation Department, the municipal and superior courts and numerous other local, state and federal criminal justice agencies. The primary function of JDIC is to provide County law enforcement agencies instant access to local, state, and federal data files and communication throughout the County, state, and nation. The optimal way to receive a SCAR is through JDIC, which should eliminate the unnecessary delays in using fax machines or email which may not be checked for days.

[11] For the Sheriff's Department, at least four hours of training on Child Abuse and E-SCARS should be made mandatory annually in: (1) Patrol School; (2) Field Training Officer School; (3) Field Operations School for Sergeants; (4) Field Operations School for Lieutenants; and (5) the Academy. This training could be coordinated by the E-SCARS Unit proposed by the DA's Office in conjunction with the LASD Special Victims Bureau (SVB). The training should include, but not be limited to: E-SCARS; understanding the role and duties of DCFS social workers and law enforcement agencies; protective custody issues; and legal updates (e.g., on mandated reporting, cross-reporting, and legislative changes).

[12] Currently, the Academy provides a four-hour training session on child abuse, but there is no training on E-SCARS. Training on E-SCARS should be included as part of the Academy's child abuse training in Learning Domain #9.

[13] In establishing the Commission, the Board of Supervisors noted that the CSIU, established in 2008, "issued a lengthy report identifying systemic flaws in the County's child protection safety network. The CSIU report on 13 child fatality incidents cited poor investigations, followed by poor decision making, failed communications, and finally, lax supervision and management within DCFS as 'Recurring Systemic Issues,' which caused deadly failures in the County's child protection duties. The recurring problems identified by CSIU appear to have been factors in the alleged mishandling of Gabriel F.'s case." Board Motion Establishing a Blue Ribbon Commission on Child Protection. June 18, 2013. P.2.

[14] "The Los Angeles County ICAN Child Death Review Team is comprised of representatives of the Department of Coroner, Los Angeles Police and Sheriff's Departments, District Attorney's Office, Los Angeles City Attorney's Office, Office of County Counsel, Department of Children and Family Services, Department of Health Services, County Office of Education, Department of Mental Health, California Department of Social Services and representatives from the medical community." It meets monthly to review child deaths in Los Angeles County. ICAN Child Death Review Team Report 2012. P.ii.

[15] As mentioned later in the report, the Commission agrees with a recent proposal by ICAN that "law enforcement personnel responding to domestic violence calls should inquire and physically check for the presence of children in the home. If present, children should be interviewed separately from the adults for signs of physical or emotional injury." In appropriate cases, a "report should be made to DCFS regarding suspected risk to the children's safety and well-being."

[16] ICAN should update the following protocols and include them in County-wide multi-disciplinary training: the Guidelines for the Effective Response to Domestic Abuse; the Los Angeles County Child Abuse and Neglect Protocol; and Multi-Agency Identification and Investigation of Severe Nonfatal and Fatal Child Injury.

[17] Relevant entities should work together on developing the factors that would serve as "triggers." When appropriate triggering factors are identified, an alert email should be sent immediately to DCFS, law enforcement, and District Attorney's Office supervisors, who would then have to acknowledge receipt of the alert. Work already being done by entities, such as DCFS and ICAN, to develop predictors for high-risk cases should be coordinated with this effort. Triggering factors could include: allegations of physical abuse; children age five and under; unrelated adult male in home; and history of family violence or drug abuse.

[18] Dr. Emily Putnam Hornstein, Director of the Children's Data Network in the School of Social Work at the University of Southern California, provided the Commission with this crucial information about children at risk. A recent report by ICAN and other reports suggest similar trends.

[19] Reforming the Los Angeles County Department of Children and Family Services: Recommendations from Los Angeles Social Workers, SEIU Local 721, December 2009.

[20] Over the past few years, in LA County approximately 8,700 to 9,000 children in foster care are placed with relatives. This represents over half of the children in foster care. California Child Welfare Indicators Project, http://cssr.berkeley.edu/ucb_childwelfare/pit.aspx

[21] Placement with kin: (1) reduces the trauma of parental separation; (2) helps children maintain familial, community, and cultural bonds; (3) provides children separated from their parents with a sense of belonging and identity; (4) results in fewer placements, additional reports of abuse, and re-entries to care; and (5) results in fewer behavioral problems, psychiatric disorders, and school disruptions, particularly if adequate mental health and educational services are provided.

[22] In the County, a non-relative caregiver might receive less than half of the amount an unrelated foster parent would receive for the care of the same child. If that child had special needs, the difference would be greater. If not federally eligible (based on the 1996 AFDC income guidelines), a non-relative caring for a child would receive state-only AFDC-FC in the amount of $820 a month. A relative caring for the same child would receive only $351 (from CalWORKs). If this relative were caring for a child with special needs, such as a severe emotional disturbance, he or she still would receive only $351. But, a licensed care facility would receive $1,220 for caring for that child.

[23] Despite the fact that kinship caregivers are often elderly, impoverished, and not expecting new caretaking responsibilities, they have minimal access to assistance. DCFS operates only two Kinship Resource Centers staffed by a total of seven social workers and one supervisor. Essentially, there is one staff person for every 1,265 children placed with relatives in open placements, closed placements (adoption and Kin-GAP), and diverted families (Probate). Kinship caregivers routinely are discouraged from engagement with the child welfare system and the decision-making process for the child. When they do engage, they often are met with informational, legal, financial, health, and social difficulties. Providing additional social workers specifically for kinship is only an effective solution if the child welfare system shifts to a culture that values the role and contribution of relative care givers equal to the value placed on other types of placements.

[24] To compound their problems, kinship families in need often do not receive appropriate levels of supports from other financial assistance programs, including Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Medicaid, child care services, or housing programs. Even with these challenges, the evidence of improved outcomes for children placed with relative caregivers is clear and growing.

[25] Gordon, 2003; Lawrence-Webb, 2006; Wilder Research, 2012; U.S. Department of Health and Human Services, 2001; The Annie E Casey Foundation, 2012.

[26] Examples include:

- Allowing foster youth receiving CalWORKs benefits to qualify for other supports, including funds for transportation to their school of origin, clothing allowances, infant supplements, and specialized care increments.

- Providing emergency funds to relative caregivers through DCFS and DPSS for child care, clothing, food, beds, and other basic needs upon initial placement to make sure relatives are able to keep the children in their home.
- Having DCFS social workers complete the application for CalWORKs benefits on behalf of children placed with relatives who do not have open cases.
- Improving the efficiency and approval rates of the Adoption and Safe Families Act (ASFA) compliance functions. ASFA was enacted as Public Law 105-89 in 1997. It maintains many points of the Adoption Assistance and Child Welfare Act, PL 96-272, but changes the focus, making states balance family preservation and family reunification with the safety of children. Among its many provisions, ASFA ensures that: (1) foster homes and other institutions where children are placed meet national standards regarding admission, safety, sanitation, and civil rights protection, 42 U.S.C. § 671(a)(10); (2) if ASFA approved, there are adoption assistance payments and foster care maintenance payments, 42 U.S.C. § 672; 42 U.S.C. § 673; and (3) criminal records checks must be completed for all foster and adoptive parents, and denial of applications where such checks reveal convictions for listed offenses, 42 U.S.C. § 671(a)(20)(A). Under ASFA, foster parents and relative caregivers' homes are evaluated using the same standards. Timeframes for ASFA compliance are out of sync with the timeframes in which Emergency Response CSWs must make immediate placement decisions. ER CSWs often discover they must momentarily detain and place children in a matter of mere hours, while ASFA staff typically requires 30 days to complete referrals for relative assessments, even when fully staffed. According to the Kinship Division, 30-days is insufficient time to complete assessments, due to high caseloads, exceptional complexities of the referred families, large amounts of corrective or follow up work the relative must complete before the home may be approved, a large number of family and significant adult contacts that must be cleared to meet compliance standards, and extremely tedious workloads, including some referrals that require visits to homes in counties in the far reaches of the State. Most often, children are placed in non-relative care by the time ASFA begins their assessments. Further, needed funding for children is often delayed for a variety of factors that preceded ASFA's involvement. This is most disheartening when Non-relative Extended Family members come forth and request the placement of children with whom they and/or the family is familiar; however, they are ineligible for any financial assistance (except for GRI under certain circumstances). And relatives who apply for and await TANF funding, which is less than foster care payments, often wait 60 or more days before funds are dispersed by DPSS through their approval processes. Further, DCFS should pursue all possible ASFA exemptions allowed to permit the homes of relative caregivers to receive approval.
- Increasing the number of DCFS social workers assigned to the kinship division. With a caseload of 1,265 children per social worker in the kinship division, helpful responsive social work practice is an impossible scenario.
- Increasing the number of kinship centers in the County, locating new centers in areas of highest need based on conditions of poverty and the prevalence of relative caregivers. Creating locally-based kinship centers in high kinship density areas in the County would provide much needed support to families, improve preventive supports, and separate DCFS' kinship support from its ASFA compliance functions.

[27] "By statute, FFAs are organized and operated on a non-profit basis and are engaged in the following activities: recruiting, certifying, and training foster parents, providing professional support to foster parents, and finding homes or other temporary or permanent placements for children who require more intensive care." California Department of Social Services, http://www.childsworld.ca.gov/pg1346.htm.

[28] (SAHMSA, 2004)

[29] For example, Point of Engagement was eliminated as an approach to services at the beginning of this year. The community was not officially notified of its elimination. Community groups and clients of the system, who should be at the center of planning and providing critical services, feel devalued and unheard.

[30] Today, the Bureau of Contract Services in DCFS consists of five divisions: Out-of-Home Care Management, Community-Based Support, Youth Development Services, Procurement and Contracts Administration, and Contracts Monitoring. The Bureau of Contract Services oversees 444 DCFS contracts worth over $550 million dollars, supporting services for nearly 7,000 families across Los Angeles County. These figures do not include contracts with affiliated departments (e.g., wraparound services supplied by DMH).

[31] Child Welfare Initiative, Report to the Los Angeles County Blue Ribbon Commission on Child Protection, Summary of Public Funding, Priority Populations Among Children and Youth, and Recommendations for Children's Mental Programs and Services. February 19, 2014. Pp.2-3.
[32] Child Welfare Initiative, Report to the Los Angeles County Blue Ribbon Commission on Child Protection, Summary of Public Funding, Priority Populations Among Children and Youth, and Recommendations for Children's Mental Programs and Services. February 19, 2014. P.3.
[33] 2014 California Children's Report Card. Children Now. P.47 (endnotes omitted).
[34] Commission for Children and Families Recommendations to Blue Ribbon Commission. December 13, 2013.
[35] Testimony of Wendy B. Smith, Ph.D., LCSW, Associate Dean, USC School of Social Work, February 21, 2014.
[36] Testimony of Wendy B. Smith, Ph.D., LCSW, Associate Dean, USC School of Social Work, February 21, 2014.
[37] 2014 California Children's Report Card. Children Now. P.47.
[38] Two Commissioners opposed a newly established Oversight Team and believed the oversight function could be performed by an existing County entity, such as ICAN or the Commission for Children and Families.