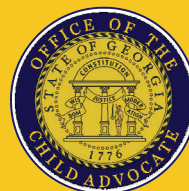


# *Office of the Child Advocate 2008 Annual Report*



***Tom C. Rawlings, Director***

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[www.gachildadvocate.org](http://www.gachildadvocate.org)



## Office of the Child Advocate

*Tom C. Rawlings, Child Advocate*

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January 16, 2009

Honorable Sonny Perdue  
Governor, State of Georgia  
203 State Capitol  
Atlanta, GA 30334

Honorable Casey Cagle  
Lieutenant Governor  
240 State Capitol  
Atlanta, GA 30334

Honorable Glenn Richardson  
Speaker of the House  
332 State Capitol  
Atlanta, GA 30334

Dear Governor Perdue, Lt. Governor Cagle, and Speaker Richardson:

Enclosed is the annual report of the Office of the Child Advocate required by OCGA § 15-11-174 (5) covering our activities for calendar year 2008 and providing our legislative and policy recommendations for 2009.

As each of you well knows, bureaucracies can be wonderfully efficient at producing results for citizens but are not always effective at tailoring those results to the needs of individuals. Our small agency considers it our privilege and responsibility to help ensure our state addresses the individual needs of at-risk children and troubled families of this state and treats each person justly, decently, and fairly.

In the attached report you will find that we are generally pleased with the direction of our state's child welfare system as it moves to keeping children safely with their families and to avoid removing them needlessly to foster care. We do, however, recommend changes that our General Assembly and child welfare agencies should implement. We believe these recommendations will improve the public's confidence in our child protection system and will promote the goal of addressing each child's individual best interests.

We also provide information in this report regarding our general operations, especially the progress on our merger with the State Office of Child Fatality Review and our partnership with the Governor's Office for Children and Families. You will be pleased to know that we have been successful in maintaining our ability to do the work while realizing significant cost savings from combining the operations.

On behalf of my staff and myself, I want to thank you all for the opportunity to serve and to thank you for your leadership of our great state.

Best Regards,

TOM C. RAWLINGS  
Director

The Honorable Sonny Perdue  
Governor of Georgia  
203 State Capitol  
Atlanta, Georgia 30334

Dear Governor Perdue:

On behalf of the Advisory Board of the Office of the Child Advocate (OCA), I would like to commend OCA's efforts during 2008 and offer our support for the vision and mission of the office. As evidenced by the thoroughness of the attached report, the newly reorganized OCA has been able to increase its efficiency and focus more of its resources on the effectiveness of the system's response to the problems of child abuse and neglect.

Statutorily, OCA has more than accomplished its duties. They continue to receive, resolve and refer complaints made regarding abused or neglected children, but with an overall eye toward "why" rather than merely "what". The staff has analyzed the trends in child well-being in Georgia and discovered both successes and challenges in the system. The philosophical shift from finding problems to discovering solutions has allowed the identification and recommendation of 'best practices' to improve our efforts.

Through the Office's proactive philosophy, they have been instrumental in educating policymakers and providers, as well as advocating for positive change based on extensive research. Their increased focus on data driven programs and collaborative communication will help policy makers create better laws to protect our children; child advocate organizations develop better programs to serve these children; and families better skills to prevent the abuse from occurring.

OCA's Legislative Initiatives and recommendations are thoughtful, timely and based on strong research, both by their staff and experts in the field. We encourage consideration of these suggestions by the legislature and relevant state agencies.

We applaud OCA for their diligence and energy during this economically trying time in their restructuring for greater efficiency, seeking broad input for changes needed and working tirelessly to create a vision that will improve the future of Georgia's children.

Respectfully submitted,



Kathy O'Neal  
Chairperson  
Office of Child Advocate Advisory Board

# Georgia Office of the Child Advocate 2008 Annual Report

## Quick Jumps:

- **State of Child Welfare**
- **OCA's 2009 Legislative Proposals**
  - [Expediting Permanency for Children Act](#)
  - [Child Abuse Treatment and Prevention Compliance Act](#)
  - [Improving Safety for Newborn Act](#)
- **OCA's Top Five Recommendations to Policymakers**
  - [Improve Medical Review of Traumatic Child Injuries](#)
  - [Institute and Consistently Apply "Alternative Response" Policies and Practices](#)
  - [Enforce Limits on the Use of "Safety Plans" and "Safety Resources"](#)
  - [Pay Attention to Our Runaways](#)
  - [Re-evaluate Foster Care Licensing Rules](#)
- **OCA's Activities – Calendar Year 2008**

## Introduction

In 2009, Georgia's Office of the Child Advocate for the Protection of Children (OCA) begins its 9<sup>th</sup> year of service to the people of Georgia and especially to those children and families who need the protection of and services provided by our child welfare system. Both the families who use our state services and those whose taxes pay for them deserve a system that improves the lives of our children and strengthens their families. Georgians also deserve a system that regular folk can understand and access. At OCA, we focus on how the system is working for ordinary Georgians and let policymakers, legislators, agency leaders, and the public know both what is working and deserves praise and what needs improvement.

With our objective in mind, we present OCA's annual report, prepared pursuant to our legislative mandate.<sup>1</sup> In it you'll find our thoughts on how the system is working, a description of the work we are doing as an agency, and our legislative proposals and policy recommendations for the coming year.

## The State of Child Welfare: A 2008 Retrospective and a Look Forward to 2009

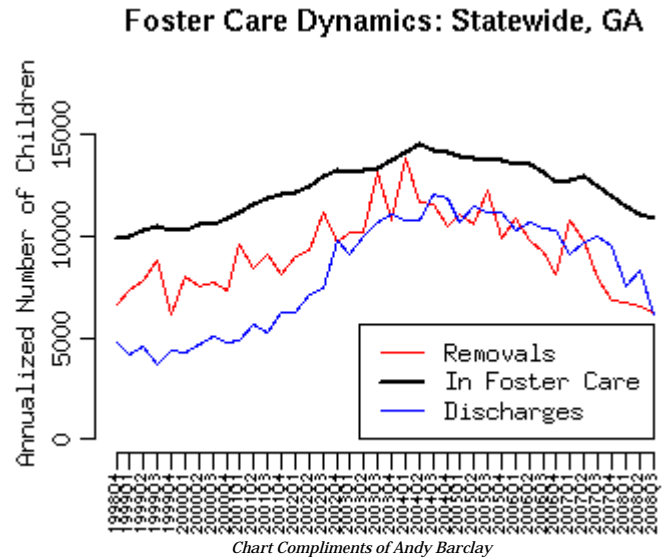
Many surveys and reports on the status of "child welfare" in a state or country focus on how children themselves are faring on benchmarks such as high school dropout, teen pregnancy and juvenile delinquency rates, infant mortality, or child poverty. This is not one of those reports.

This report, rather, focuses on how Georgia's state child welfare agencies, with their partners, are responding to one specific societal ill: child abuse and neglect, and the trauma and pain it causes its victims. In such a report, while statistics on issues such as the frequency of child abuse are helpful in explaining the problems we face, they are not the central focus. That focus is and should be on whether our response to the problem is adequate, whether our use of resources is efficient and effective, and whether we should try a different approach.

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<sup>1</sup> OCGA § 15-11-173 (5).

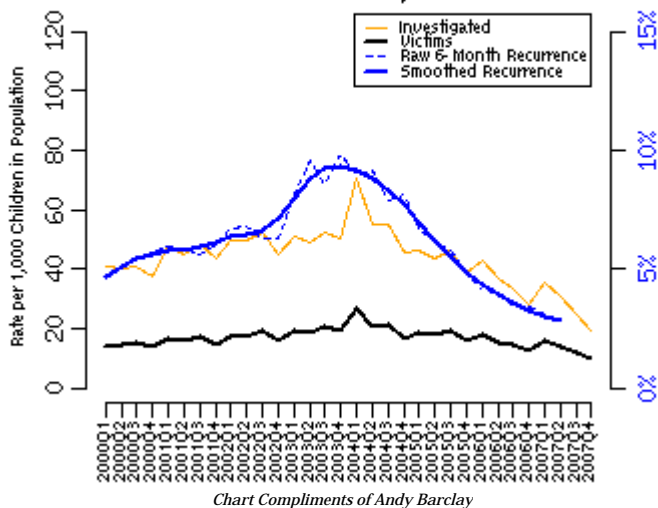
We begin with a bit of encouraging historical trend data. In 2004, Georgia removed 12,000 children from their homes and had almost 14,500 children in foster care at any given time. We are doing a better job now of keeping children with their families, and those foster care numbers are down to approximately 11,000 today. Children who must go into foster care are now spending less time there, as well. While the typical child who entered foster care a decade ago spent four years in the system, we are now returning children to family or a permanent home in a median time of 10 months. And despite fewer removals from the home, fewer children are suffering a second incident of abuse. In 2004, 9% of child abuse victims were re-abused within six months; today, our six-month recurrence of abuse rate is down to 3%.<sup>2</sup> We are moving away from the use of foster care as a panacea for all child maltreatment cases, and these statistics strongly suggest that making the effort to keep children safely in their own homes is the right approach.



While we appear to be on the right track in keeping children safe with their families, significant obstacles remain. In 2007, fifty-nine of Georgia’s children died<sup>3</sup> from abuse. A comprehensive federal review of Georgia’s child welfare system in 2007<sup>4</sup> found us deficient in several areas. Some of the federal government’s major concerns were:

- “[T]he agency’s lack of consistency in assessing the needs of children and families, identifying appropriate services to meet those needs, and ensuring that the services meet the intended goals for children and families.”
- The state’s “difficulty with regard to achieving timely permanency for children in the foster care system. In many cases, permanency goals were not identified in a timely manner, and the goals were not the appropriate goals for children, given their circumstances.”
- “[A] shortage of foster homes identified for children with more intensive emotional/behavioral problems.”

### Child Protective Services Dynamics Statewide, GA



To correct the deficiencies noted in this federal critique, leadership for the Department of Family and Children Services (“Department”) has adopted a “program improvement plan (PIP)” focusing on bettering the state’s outcomes on safety, permanency, and well-being measures for children who have been subjected to abuse. In 2008 and over the coming few years, the Department will focus its efforts on (1) investigating child abuse reports quickly and performing better assessments of families to reduce the risk of harm to children; (2) improving permanency planning for children, whether they will be returning to family or moving to adoption; (3) engaging the entire family into the planning process to better meet the needs of both child and family; and (4) improving caseworker contact with children and parents.<sup>5</sup> Failure to meet the goals of this PIP by 2010 could result in a federal fine of more than \$8 million against the State.

Another challenge facing the state’s child welfare system is the ongoing settlement in the Kenny A. v. Perdue lawsuit

<sup>2</sup> This standard – “the percentage of children with a substantiated maltreatment who suffered a second substantiated maltreatment within six months” is a federal measure that all states must report.  
<sup>3</sup> These deaths are those reported in National Child Abuse & Neglect Data System (NCANDS), so those 59 were just the ones reported to Department. The federal definition for NCANDS reporting is: “The child died as a result of abuse or neglect, because either: (a) an injury resulting from the abuse or neglect was the cause of death; or (b) abuse and/or neglect were contributing factors to the cause of death.”  
<sup>4</sup> Child and Family Services Review, available at [http://www.gacsrp.org/docs/GAFinalReportRound2\\_September2007.pdf](http://www.gacsrp.org/docs/GAFinalReportRound2_September2007.pdf)  
<sup>5</sup> Georgia Program Improvement Plan, available at <http://www.gacsrpip.org/>



brought by Children's Rights, Inc., a New York-based public interest law firm. Affecting all foster children in DeKalb and Fulton Counties, the 2005 settlement requires monitoring by "accountability agents" until the state has demonstrated compliance with 31 outcome measures and additional process measures.<sup>6</sup> In the fall of 2008, the plaintiffs' attorneys sought to hold the state in contempt for failing to move a sufficient number of children to permanent homes within a given time period agreed to in the settlement. The state and plaintiffs resolved that conflict with an agreement that Casey Family Programs,<sup>7</sup> a national nonprofit, will work closely with the state to improve permanency outcomes for those children, many of whom have serious emotional and behavioral disturbances. It is likely, however, that continual sparring between the state and plaintiff attorneys over compliance with the settlement will continue to require additional budgetary and personnel resources in the coming years.

The country's economic woes also hit home in 2008, as state agencies were required to propose budget cutbacks of 6, 8, and 10%. While these cutbacks are necessary, they must be done in a way that minimizes the impact on services to children and families. Protecting children from harm and addressing the physical and mental health needs of families requires the involvement of numerous state agencies and private providers. Unfortunately, the tendency in any government agency is to focus on its own budget and its own staff. Proposed cuts in any single agency, therefore, may not

reduce overall state costs but may simply shift those costs to another agency. A cut in funding for therapeutic foster care for behaviorally-disturbed children, for example, may end up increasing state expenditures if those children do not receive the treatment they need and find themselves in a state psychiatric hospital or a juvenile detention center.



*Joe & Randy Thomas with their newly adopted son, Johnny*

Fortunately, state agencies are working to combine efforts to treat children. Following the example of Georgia's KidsNet program and its "system of care" model, the Governor's Office for Children and Families is funding the creation of cross-agency systems of care in several parts of the state. The Department and the First Lady's Children's Cabinet are also implementing local interagency planning teams. In each of these models, local agencies and providers team up to serve those children who are involved with multiple agencies. Often these children are in foster care, have mental health issues, and may be at risk for juvenile delinquency. By ensuring that every agency is at the table, systems of care optimize each agency's resources to help the child. In 2009, the Children's Cabinet will begin another initiative that will help guarantee that costs are not merely "shifted" in this time of tight budgets. Leadership of the child-serving agencies will come together to "map" their expenditures on behalf of children and families to determine where there is duplication and where there are gaps in coverage. By mandating that all agencies work together to fund a continuum of care for abused and neglected children and their families, the state can make the most effective use of its limited tax revenues.

The effective and efficient use of state resources is especially critical as our state moves to implement a more "family-centered" practice model within the child welfare system that focuses first on keeping children safe in their own homes and with their own families. As OCA has carried out its function as the "ombudsman" for child welfare, we have encountered cases in which the Department's goal of keeping children safe at home was admirable but the implementation of that goal disregarded the lack of sufficient community infrastructure. Through its "Diversion"<sup>8</sup> strategy, the Department attempts to reduce caseloads and assist families by referring them to community resources.<sup>9</sup> But in rural areas, when parents are addicted to drugs or children have severe mental health needs, adequate resources often are not available or accessible. Strategies such as Diversion can be effective so long as the Department focuses on ensuring outcomes for children; unfortunately, OCA has expressed concern in some situations that Diversion was used as a method of controlling caseloads rather than a method of serving families. Inappropriate focus on caseloads rather than outcomes may translate into a child's improperly remaining in squalid living conditions with drug-addicted parents or a sexually reactive child who need intensive treatment being inappropriately placed in a basic foster home. OCA also examined a number of cases in which the Department did not completely address the family's issues *or* help the child truly find

<sup>6</sup> The Kenny A. case details can be found, and progress on the case tracked, at [www.childwelfare.net/activities/kennya/](http://www.childwelfare.net/activities/kennya/)

<sup>7</sup> [www.casey.org](http://www.casey.org)

<sup>8</sup> Also known as "Family Support"

<sup>9</sup> DHR press release Oct. 3, 2005, found at <http://dfcs.dhr.georgia.gov/portal/site/DHR-DFCS/menuitem.8237042e9dbda3aa50c8798dd03036a0/?vgnnextoid=58dfadcebdd07010VgnVCM100000bf01010aRCRD&vgnextchannel=b7d3d2792f178010VgnVCM100000bf01010aRCRD>

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“permanency.” Rather, in these cases, the Department merely facilitated a “safety resource” placement by allowing a parent to send the child to a relative in another part of the state for many months or allowed the parent to place temporary guardianship of the child with a relative or family friend, only to take the child back into the same situation after the Department closed its case. Fortunately, new Department assistant commissioner Mark Washington appears intent on measuring Department success through appropriate use of data collection and analysis focused on child and family-centered outcomes.

OCA’s experiences led us in 2008 to advocate for improvements in “Diversion” policy and practice, for more conscientious use of temporary relative placements, and for more appropriate assistance to children with severe mental or emotional disturbances. During the coming year, OCA will continue to support the goal of keeping children safe at home when possible but will also advocate for individualized treatment based on each child’s needs. We also believe the new “Fostering Connections to Success and Increasing Adoptions Act,”<sup>10</sup> passed by Congress in October 2008, will provide helpful direction to the Department’s focus on real permanency for children. Among its provisions, the Act gives states greater flexibility to use federal funding to support adoptions and permanent placements with relatives.

From time to time during 2008, news media reported on deaths or serious injuries of children at the hands of abusers in situations suggesting the Department should have intervened earlier and could have prevented the tragedy. From cases such as the horrific January abuse of Aiden Richards in Effingham County<sup>11</sup> to the May death of Amiya Brown in Fulton County, OCA has taken steps to review what, if anything, the Department could have done differently. Some of the recommendations we have made in our annual report flow from those analyses.

The public should remember, however, that those horrific stories are the exception rather than the rule. There are many tales of families who, through the intervention of the Department and the juvenile courts, are able to turn their lives around and be reunited. Unfortunately, our system often lacks the transparency required to allow the public to balance these tragedies against the good work of the committed social workers, lawyers, judges, and medical professionals who assist these families. Through the involvement of Court Appointed Special Advocates, foster parents, citizen review panel members, and other volunteers, ordinary citizens come to understand just how our state resources are assisting families in need. As a state, we should take further steps to promote transparency and community involvement.

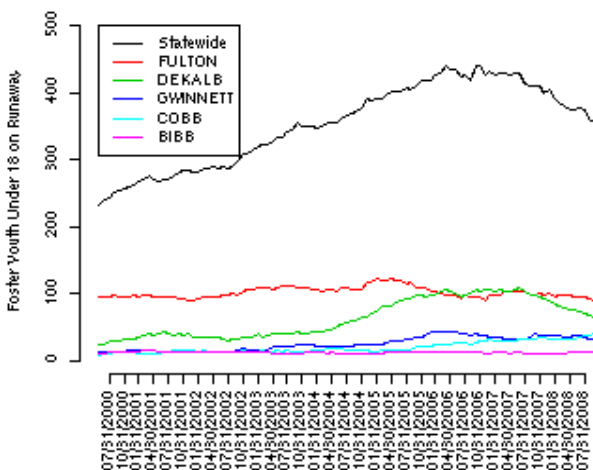


*Tina Marie Richards, of Guyton, was sentenced to 21 years for abusing her child.*

State agencies must also remember the value of our private providers, many of which are faith-based charities. In 2008 alone, approximately 80 such providers stopped delivering services. Agencies such as Lutheran Services, the Methodist

Children’s Home, Twin Cedars, and Hillside support our most troubled children with therapy, counseling, and residential treatment. Each year these agencies reach out to their communities for charitable contributions, bringing in millions of dollars that help leverage our limited tax revenues as we serve these children most in need. But as revenues fall and fewer children are placed in state custody, these charitable providers are hard-pressed to stay in business. New Medicaid regulations and audits and strict regulation by the State Office of Regulatory Services have also dramatically increased the costs for these providers. In many cases, these closings deprive our state of infrastructure built and paid for by charitable contributions that will no longer be available to subsidize our care for children. Rather than simply determine these private resources are no longer needed because fewer children are in custody, the state should work closely with providers to support them, assist them, and re-purpose them as intensive community-based providers and short-term residential treatment facilities.

**Georgia Foster Care Runaways over Time, Top 5 Counties**



*Chart Compliments of Andy Barclay*

<sup>10</sup> H.R. 6893, a summary of which is available at [http://www.clasp.org/publications/FINAL\\_FCSIAA\\_LongSummary.pdf](http://www.clasp.org/publications/FINAL_FCSIAA_LongSummary.pdf)  
<sup>11</sup> Source: <http://savannahnow.com/node/455721>

One significant opportunity for 2009 will be improving the way Georgia addresses the needs of older foster youth. The past year saw some successes in this area, including new rules allowing former foster children to receive Medicaid until they turn 21 years of age. Despite that success, there is much work to do to improve our care of older children. Too many of them, over 8%, “age out” of the system without ever finding a permanent, safe home. Over 300 children, mostly teens, were on “runaway” status in 2008, and OCA’s analysis determined that the Department was making insufficient efforts to find many of those children. The “Fostering Connections” Act passed in October 2008 will help by requiring the Department to take additional steps to assist older youth in making a successful transition from foster care to independence.

In sum, Georgia’s child welfare agencies are making progress toward creating a system that supports children and families where they live. But there will continue to be bumps in that road, and to avoid those bumps our state’s leaders must keep three key points in mind:

1. We cannot keep children safely in the community without both sufficient community support for our work and sufficient community resources to address the needs of the children and their families;
2. Addressing the needs of children requires a budgeting and planning process that focuses on the services provided, not on the agency providing the services. Innovations such as cross-agency budgeting and the system of care approach can, therefore, make a great impact on improving these services; and
3. There is no panacea for child abuse and neglect. Today’s issues may call for intensive in-home therapy, while tomorrow’s may require a residential placement. By keeping our entire system of public and private providers vibrant and vital, we will be well-prepared to address the individual needs of our children and families in future years.

## **OCA’s Work in 2008**

### Merging OCA and the Office of Child Fatality Review: Reorganizing for Efficiency and Effectiveness

One of OCA’s greatest opportunities during the 2008 calendar was implementing the “Child and Family Services Strengthening Act of 2008.” In passing this new law, the General Assembly evinced its desire that several of our state’s smaller child-serving agencies team up for greater efficiency and effectiveness. OCA assumed the staff, budget and agency resources of the Office of Child Fatality Review (OCFR) with the organizational goal of combining OCFR’s talent for gathering and analyzing the causes of child deaths with OCA’s expertise in analyzing child welfare outcomes. Additionally, the Act combined the Children’s Trust Fund and the Children and Youth Coordinating Council into the Governor’s Office for Children and Families (GOCF), bringing together the program development, oversight, and grant-making skills of those two agencies into a single entity that provides support for services to children of all ages. OCA and GOCF are already working together on joint projects, as will be discussed below. In early 2009, OCA’s Atlanta operations and GOCF moved into shared office space at 55 Park Place, near Five Points. This co-location will give the two agencies the opportunity to work closely together to improve our state child welfare and juvenile justice systems. The Child Fatality Review Panel will continue to issue an annual report separately.



our child protective system. This reorganization also realized significant cost savings, as OCA was able to create a smaller team of child welfare analysts to perform this new mission.

In conjunction with the merger of the agencies, OCA reorganized the child welfare investigative unit located in Macon to re-focus the unit’s mission. To achieve the ombudsman, “troubleshooting” function given the agency in its legislative mandate, OCA added personnel whose skills offered depth in analyzing child welfare outcomes and performing both quantitative and qualitative analysis of the Department’s operations. Essentially, the unit transformed itself into a team better able to respond to public complaints about the Department and determine both short-term and long-term solutions to the issues facing



Falling state revenues during the last half of the calendar year required some cutbacks in travel, supplies, and personnel, but the “new” OCA remains well-structured and equipped to fulfill its mission in 2009. Perhaps the most disappointing but necessary cutback was the loss of a \$70,000 legislative appropriation to conduct a statewide analysis of the needs of Georgia’s at-risk families and the resources available to meet those needs. OCA will, however, continue that work in 2009 on a smaller scale in tandem with GOCF. We will also make efficient use of our limited resources by conducting regional trainings and workshops jointly with GOCF.

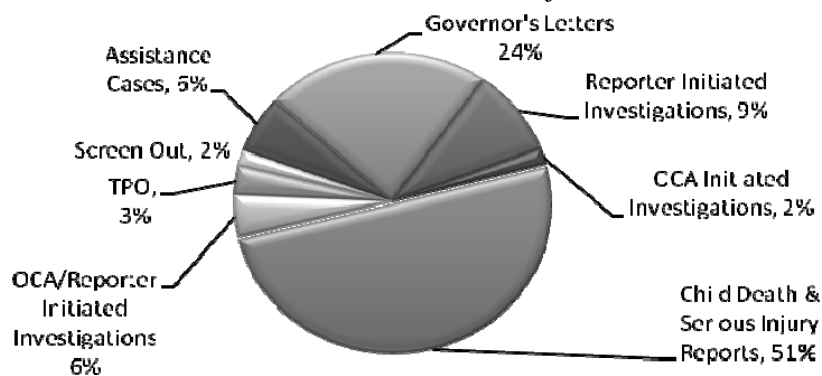
**OCA’s Core Ombudsman Work: 2008 Review**



The central mission of the Office of the Child Advocate is and traditionally has been to “identify, receive, investigate, and seek the resolution or referral of complaints made by or on behalf of children concerning any act, omission to act, practice, policy, or procedure of an agency or any contractor or agent thereof that may adversely affect the health, safety, or welfare of the children.”<sup>12</sup> While reorganizing its child welfare investigative unit, the agency continued to address specific concerns from the public regarding our state’s child welfare system. We opened 118 new investigations in calendar year 2008; of those, 87 (74%) were closed within the year and 31 (26%) remained open at year’s end. These cases remained open a median of 71 days.

As noted above, the ombudsman function saw major personnel changes in 2008. Perhaps the greatest change, however, came in how the unit processes and monitors problematic cases. First, we were fortunate to receive a legislative appropriation that allowed us to switch to a web-based version of our case tracking software, giving our personnel greater flexibility in working from remote locations. Under the direction of our new operations program manager, Wendy Kallina, Ph.D., we began tracking our responses to complaints much more closely to determine both the source of those public concerns and the specific issues raised. We also gained access to the new DFCS database, SHINES, which allowed us to review the work of Department case managers much more efficiently and respond more quickly to concerns raised. Using these changes in technology and in procedure, we began the longer-term process of determining from specific complaints trends affecting our child welfare system. During the latter half of 2008, for example, we used SHINES access to review all Diversion practices in a specific county and develop some conclusions from those case reviews. We have also begun tracking all the Department’s Child Death and Serious Injury incidents to better spot common trends and causes among those severe incidents. As figure 1 below suggests, the Child Death and Serious Injury reports will constitute a much larger source of our work going forward. We will also continue to work closely with Andy Barclay, whose statistical analysis of our state’s child welfare system, has been outstanding. These changes are the result of our effort to make OCA’s ombudsman function both more responsive and more proactive. Rather than merely respond to concerns about the system long after the fact, in 2008 our ombudsman staff were able in numerous instances to intervene on behalf of constituents in ways that improved their satisfaction with the child welfare process.

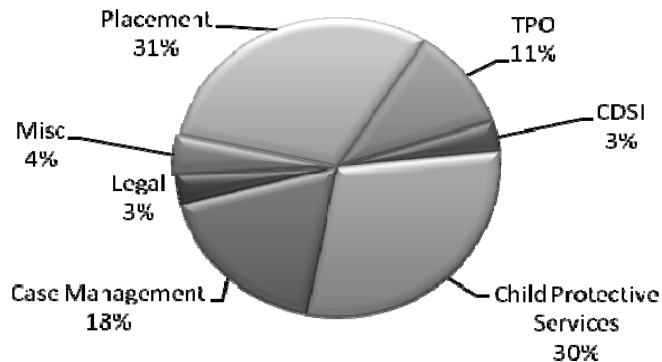
*Figure 1: Sources of OCA Ombudsman Cases, July 1-December 31, 2008*



<sup>12</sup> O.C.G.A. § 15-11-173 (1).

In general, complaints in 2008 from parents who are involved with DFCS constituted a third of our agency's referrals. Grandparents, family members, and professionals also made a significant percentage of referrals. When it came to matters that were investigated, however, many of those referrals originated from sources such as media coverage of significant child abuse cases. As figure 2 indicates, some of the major issues we addressed in our investigations were concerns about appropriate placement, concerns about the way the Department is working with a family and managing their case, and concerns about the appropriateness of CPS investigations. Specific breakdowns of the types of issues covered by each general category are given in Appendix 1.

*Figure 2. Types of issues raised by investigations, 2008 (N=118).*



#### Education: Spreading the Wealth of Knowledge

During 2008, OCA and its staff spent many hours educating policymakers, legislators, child advocacy groups, and citizens on the needs of at-risk families and how best to serve those needs. A few of these activities deserve to be highlighted.

#### ***Justice for Children Judicial Summits***

Joining with the Department and with the Supreme Court's Committee on Justice for Children, OCA helped conduct educational summits in nine judicial circuits during 2008. Each summit, hosted by the local juvenile court judge, brought together all those involved with the local child welfare system. At each summit, speakers gave substantive presentations on social work and legal topics. Additionally, the participants reviewed the actual performance data showing the outcomes and trends for both the local court and the local child welfare agencies. Reflecting on the quantitative and qualitative information presented for the local jurisdiction, the stakeholders created action plans for improvement. After each summit, the jurisdiction continued to receive data updates each six months to help the participants implement their action plans, track their progress, and further refine their strategies and goals for improvement. This effort, led for OCA by Deputy Director Melissa Carter, helped spur local participants to work more closely together to improve their community's care of abused and neglected children.



#### ***"Finding Words": Training for Professionals Interviewing Child Abuse Victims***

Since 2003, the Office of the Child Advocate has been Georgia's home of the "Finding Words" program, a nationally-recognized training through which professionals involved in child sexual abuse investigations learn to interact properly with possible abuse victims, interview them in a neutral and non-leading manner, and present the results of those interviews in Court. This year, led by OCA's Sherry Bryant and an outstanding team of faculty from across the state, OCA trained 108 professionals in forensic interview techniques. Since its inception in 2003, OCA's Finding Words and Advanced Finding Words programs have provided this valuable training to 792 professionals from law enforcement, prosecutors' offices, child protection agencies, and the community of social service providers.

#### *FINDING WORDS GEORGIA TRAINING OUTCOMES*

<u>Attendee Type</u>	<u># Trained 2003-07</u>	<u># Trained 2008</u>	<u>TOTAL Trained</u>
CPS	204	30	234
CAC	115	14	129
DA's	70	7	77
Law Enf	252	48	300
Other*	43	9	52

\* School social workers, therapists, mentors, etc.

***Assisting the General Assembly***

As part of its key functions, the Office of the Child Advocate serves as a source of reliable information for legislators who must make tough calls on child welfare budgets and legislation. OCA carried out this duty proudly in 2008, testifying before numerous legislative committees and providing legislators with timely, researched responses to questions about child welfare law and policies. In 2009, OCA will continue to assist legislators to make good decisions by providing information, explanation, and recommendations as appropriate.

***Seminars, Speeches, Interviews, and Publications***

An important role served by OCA is assisting those who want to help our at-risk children understand how they can best serve. In that capacity, OCA staff regularly gave talks across the state to nonprofit child advocacy groups, foster parents, medical providers, local Family Connection Partnerships, and others. OCA staff were interviewed on child welfare matters by such diverse media outlets as the Atlanta Journal-Constitution, the Washington Post, and Georgia Public Television. Additionally, OCA issued its own bi-weekly column on child welfare issues that was circulated to many smaller newspapers and sent via email to a wide audience. Longer op-ed pieces this year were published in the Atlanta Journal-Constitution. And OCA staff served as keynote speakers and seminar presenters at numerous conferences, trainings, and formal and informal gatherings of juvenile justice staff, social workers, and foster parents.

**Advocacy: Seeing Opportunities, Combating Threats**

During the 2008 calendar year, OCA and its child advocacy partners worked diligently to identify and combat negative trends in child welfare and to promote and highlight system improvements. Some of the more significant OCA projects included the following:

- At the request of Juvenile Court Judge Kevin Guidry, OCA Deputy Director Melissa Carter and her team performed an analysis of the work of child advocate attorneys in Judge Guidry's Piedmont Judicial Circuit. The team's analysis included three days of court observation, review of a sample of 13 attorney case files, and surveys completed by Judge Guidry and by the two Child Advocate Attorneys. Ms. Carter and her team were able to highlight the good work of these child advocate attorneys while making specific recommendations to improve their representation of children.



- Deputy Director Carter also led an effort to identify and bring to the courts' and the Department's attention the more than 300 missing children who were listed as having "run away" from the Department's custody. She identified those who had been prematurely discharged from state custody and/or for whom diligent efforts to locate were not being made. One notable finding was that, of the approximately 100 youth on runaway who still had open, active cases with the Department, only one had an active report with the National Center for Missing and Exploited Children, in clear violation of DFCS' policy and sound case management practices. Ms. Carter's work focused attention on the needs of these children and renewed the state's efforts to find them and keep them safe.

- ♦ OCA took an active role in assisting the state citizen review panels that advise the Department pursuant to the federal Child Abuse Treatment and Prevention Act. OCA staff participate as members of those panels and combine our research and positional advocacy efforts with those of the panels. David Miller, District Attorney of the Southern Judicial Circuit and an active member of the State Child Fatality Review Panel, took on a leadership role for CFR as the CAPTA liaison between the CFR Panel and the Department.



- ♦ OCA worked closely with medical providers and the Department to better integrate the medical and social work components of diagnosing and treating child abuse and its victims. During the coming year, OCA will continue to work with pediatricians, children's hospitals, and child-serving state agencies to establish a "medical passport" for foster children, better educate pediatricians on child abuse, and further integrate medical expertise into our child protection system.
- ♦ Sarah O'Leary, a CDC fellow working with the Child Fatality Review staff, developed a comprehensive framework for a statewide child injury prevention plan that the CFR staff and OCA will be working with partners in 2009 to implement across agencies.
- ♦ OCA worked closely with "A Future Not A Past," the campaign to end commercial sexual exploitation of children, as the nonprofit went across the state meeting with law enforcement, judges, prosecutors and others to educate the public about the growing problem of child sex trafficking. That work evolved into a collaboration among child advocacy groups and state child-serving agencies. OCA worked with the Governor's Office for Children and Families as GOCF began the hard work of coordinating the infrastructure necessary to serve these victimized young girls. OCA Director Tom Rawlings also served on a legislative study committee that is recommending new approaches to fighting this horrific crime and rehabilitating its victims.
- ♦ OCA continued to work with providers of services for troubled children so those services will remain accessible and that our network of providers – many of them non-profit initiatives of faith communities – remain a viable and vital part of our child welfare system. OCA will continue to work to bring providers and government agencies together as one team working for Georgia's children.

### **Legislative Initiatives for 2009 General Assembly**

Based on its work in the 2008 calendar year, the Office of the Child Advocate has developed several legislative initiatives designed to improve our state's child welfare and child protection systems. Working with the Governor's Office staff and legislative leadership, OCA will push for these reforms in the upcoming General Assembly.

#### The Expediting Permanency for Children Act

When abused and neglected children cannot be safely returned to their parents and need a different permanent home, our child welfare laws and policies rightly focus on placing those children first with relatives. Current best practices, as reflected in federal and state law and policy, require looking for and exploring the suitability of those relatives up front, when the child first comes into foster care. It also means planning for the child's permanency so that, if the court has to terminate the parents' rights, everyone will already have laid the groundwork for giving the child a permanent home.

While the Legislature has in recent years bolstered this planning process by requiring that courts search for relatives when children first come into custody, we have more to do to make this structure efficient. First, the Congress recently passed the "Fostering Connections to Success and Increasing Adoptions Act of 2008," and one of its provisions requires the states to shorten deadlines for relative searches. Second, practitioners all know that when children come into care, parents are reluctant to identify potential relative placements because they fear they will lose the children to those relatives. Third, although our current laws lay out a very detailed planning process that includes



identifying potential permanent placement resources well before the parents' rights are terminated, our termination of parental rights statute has not been modified to reflect current planning practice.

Under this proposed Act, we would make certain children who cannot return to their parents are placed expeditiously in a safe, permanent home with families they care for and who care for them. The bill seeks this objective by:

- ♦ Shortening the time frame during which the Department and juvenile court must search for relatives and "fictive kin"<sup>13</sup> requiring that courts quickly obtain from parents a list of all potential relatives and "fictive kin" who might be considered as placements for the children;
- ♦ Requiring the Department notify relatives in writing of the situation involving the children, of the need for relatives to care for the children, and of the potential financial support available to those relatives that would help them care for the children;
- ♦ Removing the current "misplaced" requirement that the court search for and attempt to place the children with a relative *after* it orders the termination of the parents' rights. Instead, the statute would direct the court to give the child the home that, taking into consideration the court's previously-ordered permanency plan, provides the child the most permanence, is the least disruptive to the child's life, and promotes the child's well-being, best interests, and need for attachment and relationship.

#### The Child Abuse Treatment and Prevention Compliance Act

Each year Georgia receives from the federal government hundreds of thousands of dollars for child abuse treatment and prevention pursuant to the Child Abuse Prevention and Treatment Act (CAPTA). As with other federal monies, these "CAPTA" funds come with strings attached. One of those conditions is that the state must certify it provides the public access to otherwise confidential child abuse records in cases where child abuse or neglect resulted in a child fatality or "near fatality." While Georgia law already provides this access in cases involving *fatalities*, it does not allow such access in cases involving "near fatalities," which the federal law defines as "an act that a physician certifies placed the child in serious or critical condition."<sup>14</sup>

Even aside from the state's need to comply with this federal mandate, however, making these records available to the public is a good way to help the public understand the abuse children suffer and hold the child welfare system accountable. Taxpayers and citizens deserve the best child welfare system we can create. In April 2008, a 50-state report by First Star, a national child advocacy group, highlighted the states' need to comply with this important principle behind the CAPTA law. In response to that report, OCA and the Department agreed to take steps to provide Georgia's citizens access to the information they need to evaluate our state's response to child abuse and neglect cases.

Under the proposed legislation, when a child suffers a critical or serious injury at the hands of an abuser, the public will have access to the otherwise confidential records showing the Department's involvement with that child and his or her family. Making this information available to citizens, legislators, policymakers, and child advocates will help us develop better ways of fighting child abuse.

#### The Improving Safety for Newborns Act

In its role of providing staff support for the State Child Fatality Review Panel, OCA helps promote improvements that the Panel develops through its statewide review of child fatalities. One such significant legislative initiative this year will be the "Improving Safety for Newborns Act." Under newborn "safe haven" laws adopted in nearly all 50 states, mothers who simply cannot care for a young child can, without fear of prosecution for child abandonment, surrender that child at designated facilities such as hospitals. In Georgia, a mother has up to seven days after the child's birth to do so. Other states, however, place limits ranging from 72 hours to one year.<sup>15</sup>

The proposed change would allow a mother to safely surrender a child up to 12 weeks old. This change is suggested by child fatality review data and studies showing that 52% of all infant homicides by a parent occur during the first three

<sup>13</sup> "Fictive kin" refers to individuals to whom the child is strongly attached and identifies as family despite not being related by blood or marriage. Current state law uses the language "other persons who have demonstrated an ongoing commitment to the child." O.C.G.A. § 15-11-55(a)(2) (2008).

<sup>14</sup> 42 U.S.C. 5101 et seq. §§ 106(b)(2)(A)(x) and (b)(4)(A).

<sup>15</sup> Guttmacher Institute, "Infant Abandonment," *State Policies in Brief* (Dec. 2008), available at [http://www.guttmacher.org/statecenter/spibs/spib\\_IA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_IA.pdf). Nebraska, of course, infamously passed a law in 2008 containing no age limit, and over 30 children from all over the country – most of them teens – were abandoned there between August and November 2008, when the Nebraska Legislature amended the law to add a time limit.

months of parenthood when a parent is unprepared for the demands and challenges of caregiving and becomes overwhelmed. By extending the period of time in which an overwhelmed mother can safely abandon her child to a medical facility, the General Assembly can amplify the prevention and protection power of the Safe Place for Newborns Act.

#### Other Legislative Work

In addition to these legislative initiatives, OCA will be working closely with the Governor's Office for Children and Families, the Department, and child advocacy groups to craft legislative and budget policies that will best meet the needs of Georgia's children. We will be especially interested in helping to implement a new juvenile code for Georgia<sup>16</sup> and will continue our role of providing legislators with independent, objective advice on child welfare issues.

### **A Few Recommendations**

Based on our work in 2008, the Office of the Child Advocate has developed a few specific recommendations that we believe the Department's leadership should actively explore during the coming year. Each of these recommendations should be taken as a suggestion for improving critical areas of the system. Therefore, while we do not suggest our approach or solution is the only way. We do believe these issues deserve the attention of our state's leadership.

#### Recommendation #1: Improve Medical Review of Traumatic Child Injuries

##### *Three troublesome cases.*

- ♦ **Swain.**<sup>17</sup> On July 31, 2006, Amanda Swain appeared at Kennestone Hospital with her three-month old daughter. She said she didn't know what could be wrong with the child. Among other explanations, she suggested to the emergency room doctor that she perhaps had rolled over on the child while taking a nap. The doctor told the Department that the injury was inconsistent with that explanation. She later told a caseworker that she had placed the child down for a nap while she and her boyfriend were also napping. The child awoke crying, and when her boyfriend picked up the child he "noticed that her arm was limp." The child was removed and the case sent to juvenile court. After court was continued several times to obtain the critical testimony of the attending physician from Kennestone, the mother eventually agreed to deprivation based on "unexplained injuries" to the child. Child and mother were set on a path to reunification. Two years later, shortly after that reunification occurred, mother and the same boyfriend were arrested for horribly abusing the child, whose injuries landed her in the pediatric ICU at Children's Healthcare of Atlanta.<sup>18</sup>
- ♦ **Anonymous.**<sup>19</sup> In March 2008, the parents of a young child brought him to Egleston Children's Hospital. Father claimed he believed the child had a rash, but the doctors found the child had second-degree burns on his buttocks. The father said he had washed the child after a dirty diaper and had noticed the water was "a little warm." Doctors ordered a skeletal survey that showed the child had previously suffered multiple bilateral rib fractures. The Department's response was to place the child with relatives while the parents went through parenting classes that would help them better supervise the child and make them more aware of the dangers of hot water. By the time an Egleston doctor testified about the child's injuries in June 2008, the parents had already almost completed their parenting classes and the case was soon thereafter dismissed. Court and Department records indicate the Department's main concern was that the parents were ignorant of the dangers of hot water on a child. By November 2008, those parents had a new baby. This child, merely weeks old, came to the hospital suffering from "old and new subdural bleeds and rib fractures."
- ♦ **Brown.**<sup>20</sup> On May 18, 2008, 16-month-old Amiya Brown was brought to Grady Hospital's emergency room by her mother. The mother claimed she brought the child because she observed Amiya "limping when she walked." The mother claimed ignorance of how the child might have been injured. Her own mother had the child for a few days, she said, brought her home that evening, and denied knowing why the child had a limp. As it turned out,

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<sup>16</sup> The "Model" Juvenile Code, which will serve as a basis for a legislative package of new juvenile code reforms, is available at [www.justga.org](http://www.justga.org).

<sup>17</sup> While this child's information remains confidential under current state law, OCA is recapping these events because they have already been made public in connection with the arrest and prosecution of the mother and her boyfriend for this abuse.

<sup>18</sup> While the child's prognosis was grim following the abuse, OCA's Director has since seen the child and can say that this beautiful little girl has made a miraculous recovery.

<sup>19</sup> As the identity of this child remains confidential, OCA will recount the events without identifying the child or the child's parents. The use of the male pronoun here should be construed as of neutral gender.

<sup>20</sup> This child's case is subject to the Open Records Act and has been discussed thoroughly in the media.

doctors found Amiya had both a broken leg and a broken arm. Although in the medical records the doctor noted “possible physical abuse,” the responding caseworker allowed Amiya to go home with her mother. That caseworker later stated that when she spoke briefly with the doctor, he did not seem to suspect foul play in the injuries sustained by the child.” Nine days later, Amiya was dead from blunt-force trauma allegedly inflicted by her mother’s boyfriend.

### *Better Integration of Medical Expertise Can Prevent the Recurrence of Abuse*

What each of these three cases has in common is that, thanks to insufficient critical medical analysis of the causes of these serious injuries and of the parents’ proffered explanation, cases of severe abuse were treated as mere family problems requiring such mild interventions as parenting classes and counseling. And in each of these cases, the lack of this critical medical evaluation directly resulted in additional severe physical abuse to that child or his or her sibling.

Did any one person really “drop the ball” in any of these cases? Each of them required analysis from both medical and social work experts working under pressure to handle this as well as many other cases. In the Brown case, for example, the emergency room doctor did what he was required to do, diagnosing the injury and suggesting to social workers that it might be “possible physical abuse.” But with an emergency room full of patients, he likely had little opportunity to spend time with the social workers to explain his concerns in detail. He certainly had no time to discuss the probability of the mother’s contention that no one would know how a toddler suffered two broken limbs. Perhaps his inability to spend time with the caseworker led to her conclusion that “the doctor did not suspect foul play in injuries sustained to the child.” Likewise, the social worker who interviewed the mother could have benefited from having someone with the medical training and experience necessary to determine whether a child with these types of injuries could, in fact, be at severe risk of further abuse.

In the DeKalb County scalding case, likewise, the caseworker seemed perfectly willing to accept the parent’s explanation that a child with second-degree burns could have received them from water that the father found “a little warm.” That same caseworker and her supervisors seemingly dismissed the doctor’s subsequent finding of old broken ribs as inconsequential. Greater medical involvement in immediate aftermath of this case might have highlighted the significance of the broken ribs and of the burns, especially given the medical literature’s findings that 60% of all tap water scalds to children were determined to be abuse when an adult was the one running the faucet.<sup>21</sup> Nevertheless, by the time the doctor actually testified in juvenile court, this case had already been put on a track requiring the parents to do little more than attend parenting classes.

Furthermore, each of these cases required more intensive medical follow-up analysis than it received. In the Swain case, testimony by the attending physician might have shed more light on the parents’ credibility when they claimed they woke up from a nap and “found” Adrianna’s arm to be “limp” for no apparent reason. Instead, because the doctor was not a regular part of the investigative team who could make time to appear in court, the court eventually allowed the parties to stipulate to deprivation based on “unexplained injuries.”

In addition to the issue of integrating medical evidence into the investigation process, there is also the matter of improving primary diagnosis of abusive injuries to prevent their recurrence. Studies have demonstrated that when a child presents in a hospital setting with a traumatic abusive injury, there is a significant danger that abuse will not be properly diagnosed. As a result, children who have suffered abuse remain in danger of repeat abuse or death. A five-year study of children under three who presented at an academic children’s hospital showed the following:

- ♦ Fifty-four (31.2%) of 173 abused children with head injuries had been seen by physicians after abusive head trauma (AHT) and the diagnosis was not recognized;
- ♦ The mean time to correct diagnosis among these children was 7 days (range, 0-189 days);
- ♦ 27.8% were re-injured after the missed diagnosis; and
- ♦ Four of 5 deaths in the group with unrecognized AHT might have been prevented by earlier recognition of abuse.<sup>22</sup>

These statistics and cases strongly suggest that by improving medical diagnosis of child abuse and by integrating that medical knowledge into the child protective services investigation and process, we can greatly reduce those tragic abuse cases in which we realize we missed an earlier chance to intervene. The Department should work with hospitals,

<sup>21</sup>Feldman, Schaller, et al, “Tap Water Scald Burns in Children,” *Inj. Prev.* 1998;4:238-242.

<sup>22</sup> Jenny C, Hymel KP, Ritzen A, Reinert SE, Hay TC *JAMA.* 1999 Feb 17;281(7):621-6

pediatricians, and physicians with expertise in child abuse to better educate doctors on diagnosing abuse. Additionally, we should consider how we might develop a system in which a team of physicians and social workers regularly reviews every case of a child who comes to a hospital for injuries from suspected physical abuse and follows up with the Department to confirm those cases are handled appropriately.

Recommendation #2: Institute and Consistently Apply “Alternative Response” Policies and Practices.

Over the past several years, the Department has made a concerted effort to keep children in their own homes and to avoid heavy-handed investigations when possible. One of the Department’s chief means of reducing its investigative caseload has been the use of a practice originally called “Diversion” and now called “Family Support.” Diversion originally began in Fulton County as a less formal way of handling reports involving child poverty, truancy, mental health, and other matters that did not require a full child maltreatment investigation and could be addressed through a “guided” referral to other resources. Beginning in 2004, however, the practice was expanded to all parts of the state with a direction that each county determine its own protocol for deciding which cases to divert and how to process those cases.

The initiative has been highly effective in reducing DFCS involvement with families. Since 2004, the Department has diverted over 100,000 reports of child maltreatment, and the percentage of cases handled through Diversion increased from 44% in January 2008 to 53% in August 2008. There were 37,809 diversions from May 2007 to April 2008, an annualized increase of 48% in diversions over FY 2007 alone. At the same time, child protective services “ongoing” cases – those in which the Department was actively involved with a child who remained in his or her own home – decreased dramatically from a high of 32,500 in March 2004 to a low of 11,500 in June 2008.

While Diversion has effectively reduced the number of cases in which the Department is actively involved, the practice itself lacks uniform policy and lacks any consistent application or structure. In general, “alternative response” practices such as Diversion have proven highly successful in many states, providing social workers with a non-intrusive method of engaging the family’s issues while maintaining the safety of the children. But Georgia’s version of the practice lacks many of the key features and safeguards of those nationally-accepted models.

According to the American Humane Society, there are several “core elements” of a good alternative response system for child welfare professionals. These include:

- ♦ The use of two or more discrete responses of intervention.
- ♦ The creation of multiple responses for reports of maltreatment that are screened in and accepted for response.
- ♦ The determination of the response assignment by the presence of imminent danger, level of risk, the number of previous reports, the source of the report, and/or presenting case characteristics, such as type of alleged maltreatment and age of the alleged victim. Typically, accepted reports categorized as low- or moderate-risk are assigned to the non-investigation assessment response.
- ♦ The ability to change original response assignments (either decreased or elevated) based on additional information gathered during the investigation or assessment phase. An increase or decrease in threats of harm or risk level can trigger a change in “response assignment.”
- ♦ The establishment of multiple responses is codified in statute, policy, and/or protocols.
- ♦ The ability of families who receive a non-investigatory response to accept or refuse the offered services after an assessment without consequences (i.e., services are voluntary).<sup>23</sup>

Georgia’s “Diversion” practice, unfortunately, has few of those elements explicitly built in. First, the responses are not “codified” in any way, except on the local level. Rather than set a uniform statewide policy, Department leadership intentionally left it to each local county or region to determine its diversion practice. As a result, Diversion in one county may look very different from Diversion in another. In one, Diversion may consist of a brief investigation, an informal family assessment, active help with obtaining appropriate services, and follow-up to see if those services were helpful. In other counties, cases as serious as those involving prenatal drug use and domestic violence in the presence of children may be essentially referred out without a social worker ever seeing the child’s family or providing any meaningful follow-up to ensure the family connected with the recommended community services and supports.

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<sup>23</sup> Merkel-Holguin et al, National Study on Differential Response in Child Welfare (American Humane Society 2006). Yes, the American Humane Society is very involved in child welfare and is not just concerned with animal welfare.



Georgia's Diversion practice also lacks any kind of formalized family assessment – a key feature of every national alternative response model. In each Diversion case, it is up to the local agency just how deeply to dig into the family's issues and just how much work should be done to determine the family's needs. When a case is selected for Diversion, which may occur at the intake stage, no statewide policy requires a case manager to determine whether the family's history and risk level makes this case more appropriate for Diversion or investigation. Therefore, a family in one county who might be subjected an intrusive investigation might in another county receive merely a referral to services. And without a statewide family assessment instrument, families who need intervention rather than a mere referral to services might not receive it, leaving children at risk of harm.

The effort to use Diversion more, without setting parameters for its use or equipping social workers with the tools to use it properly - is unwise. An unfortunate recent case from DeKalb County may illustrate the dangers. Elijah<sup>24</sup>, age two, entered the Children's Hospital Pediatric ICU after he apparently ingested a bottle of Tylenol at his great-grandmother's house. Elijah's mother had apparently left him there and sent "a friend" to pick him up. According to the mother, the friend asked the great-grandmother why Elijah was throwing up, and great-grandmother happened to mention that she had found an empty bottle of Tylenol on the floor.

The case was assigned as a Diversion from the beginning because it appeared to be an "accidental" drug overdose. But when the case manager made contact with the family, it was clear the mother had some issues. The mother's father and stepmother indicated the 23-year-old mother lived with them but, it seems, was gone a lot without telling her family where she was. Both the case manager and the stepmother noted that the mother could not control her two children and did not seem to understand the seriousness of the child's injury or the need to comply with follow-up medical care.

Despite her expressed concern that the mother did not seem to understand her child's needs and the fact that the mother's own family could not keep up with her whereabouts, the case manager closed the matter. Three weeks later the mother and her boyfriend were arrested at a hotel in Fulton County after this child was found dead in a bathtub. The boyfriend allegedly confessed to killing the child in the bathtub while his sibling was in the hotel room.

While no one can determine that the Department's Diversion actions here directly led to this child's death and his brother's entry into foster care, it is clear that the purposes of an alternative response system were not achieved. This case manager, it seems, believed her responsibility was merely to address the Tylenol overdose. But as one expert has put it, an appropriate alternative response "approaches families more broadly from the first encounter, focusing on their situation, problems and needs, . . . in a manner that is positive and non-confrontational, supportive of family stability, strength-based and safety focused."<sup>25</sup> With the case manager and the mother's own family feeling the mother was unable to control her children or understand their needs, an alternative response policy calling for a family assessment and giving case managers the ability to provide more intensive services based on that assessment might have better served this mother and her children.

### Recommendation #3: Enforce Limits on the Use of "Safety Plans" and "Safety Resources"

Both research and common experience demonstrate that children are better off in their own homes or with close relatives if those are safe placements. Being placed in foster care is itself a traumatic experience, and social workers are right to balance the trauma of that removal against the risks to the child of remaining in the home or with a close family friend or relative. Since 2004, the Department has worked hard to keep children out of care, either by working with those children in their own homes or by suggesting to parents that the child might temporarily stay with a family member or friend – a "safety resource" -- while the Department works with the parents on their issues. This approach has enabled the Department to decrease its foster care caseloads from a high of 14,500 in 2004 to 11,000 today.

But while the use of safety resources is a good idea, its current implementation is problematic. The first issue is the vagueness of the state's own policies. While § 2104.33 of the Child and Family Services Manual suggests that children should remain with safety resources only temporarily, there are no specific guidelines for what "temporary" may be. Department staff instructs that safety resource placements are not to exceed 90 days, yet OCA has received referrals on cases in which children have been in safety resource placements for 6 months or more. In the foster care system, on the contrary, parents are generally expected to complete case plans within 12 months, and if the child remains in care after

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<sup>24</sup> Again, because this child has since died from abuse his otherwise confidential records are open to the public.

<sup>25</sup> Minn. Alt. Response Eval., Final Report (Inst. Applied Research 2004)

that point the court and agency begin planning alternative permanency arrangements.<sup>26</sup> The vague definition of “temporary” in the policy may be one reason that children are remaining in these “temporary” placements, on average, in excess of six months and over a year in some cases.

A second concern over the use of these safety placements comes from purely anecdotal evidence that these placements are not purely “voluntary” on the parents’ part or, at a minimum, that the agency does a very poor job of explaining the safety resource program. The Office of the Child Advocate has received numerous reports from parents whose children have been with a safety resource for months and were under the impression their children were actually in the custody of DFCS, or whose children were placed with relatives who then told the parents they could not visit the children because DFCS had instructed them to allow no contact. On occasion, parents have complained that DFCS threatened to remove their child *unless* they placed the child with a safety resource without explaining the parent’s right to go to juvenile court and contest that removal. The issue here is one of basic fairness and due process. Had these children been placed in foster care, the parent would generally be entitled to a court hearing, a lawyer, regular visitation with the children, a case plan detailing the steps necessary to have the child returned home, and judicial oversight of the entire process. Instead, these parents often feel pushed into sending their child to live with a relative in a different part of the state with no indication of how long the child will remain away and no system support for reunifying with their child.

This system is not the best for children, either, especially when the safety resource lives far from the child’s home. In too many cases, children are effectively uprooted from their friends and closest family and placed with relatives or family friends who live in excess of 50 miles away for an indeterminate period of time. Although the adult caretakers have no “legal” authority to do so, they must enroll these children in a different school, obtain medical coverage and care for them, and often single-handedly manage the relationship between the children and their parents. Often, these safety resources report, the Department provides little guidance or assistance to caretakers.

Recently the Department implemented a new program by which parents subjected to a Departmental investigation will be invited to place their child with a “trained volunteer” who has no prior relationship with the child. In 2008, the Department contracted with Bethany Christian Services to implement this program on a trial basis.

The Department should, at a minimum, revise its “safety resource” policies and practices as follows:

- ♦ Children should not remain in a safety resource beyond 30 days without court intervention, and the use of “informal” safety resource placements should be limited to the period of an investigation.
- ♦ If an investigation is substantiated and the child cannot safely return home, the Department should be required to seek court authorization to legally place temporary custody of the child.
- ♦ Children should not be placed out of their home counties absent special circumstances; and
- ♦ The Department should guarantee that children in safety resources may continue in their current schools; if a change in school is required, the Department should have the responsibility for enrolling the child immediately;
- ♦ The Department should have the responsibility for providing regular visitation, supervised by the Department if necessary, between parent and child; and
- ♦ The Department should have the responsibility for ascertaining that both parent and safety resource understand that the use of a safety resource is purely voluntary and should provide procedures to give unsatisfied parties access to the juvenile court process.

#### Recommendation #4: Pay Attention to Our Runaways

In her investigation of the more than 100 children in the state’s active custody who were listed as being on “runaway” status, OCA Deputy Director Melissa Carter found that only one had been reported to the National Center for Missing and Exploited Children as required by Department policy. Her analysis highlights the need for our state agencies to pay more attention to the needs of children who run away from foster care. With that goal in mind, OCA concurs in the recommendations of Emory University’s Barton Child Law and Policy Clinic on this issue:

*When placing children in foster care, Georgia should perform an assessment of children at risk for runaway and notify the foster caregiver of the children’s behaviors. This is also a policy of the Los Angeles County DCFS. Georgia should attempt to place these at risk children in foster homes that cater to their specific needs.*

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<sup>26</sup> See, e.g., the specific permanency planning and review mechanisms specified by OCGA § 15-11-58.

*DFCS should create a central database system that includes basic identifying information, i.e. height, hair and eye color. To this end, case managers should include a photo of children in case files. In the event that a child in custody runs away, this information can be used for location efforts. Additionally, Georgia should create a Child Location unit for its missing children, which includes a law enforcement liaison who works with DFCS and real time tracking.*

*The current DFCS policy is to request release of custody after children have been on runaway for 90 days. The practice should be for the case to remain on the case manager's caseload until the child turns 18. The case manager should continue to review the case and contact the child's family and friends monthly for any updates on the child's whereabouts.<sup>27</sup>*

#### **Recommendation #5: Re-evaluate Foster Care Licensing Rules**

In working with both the Department's "public" foster care homes as well as Child Placing Agencies (CPAs) – OCA has observed disparities in degrees of regulation and disparate treatment of family foster homes that provide the same level of service. While federal law and regulations permit the state to establish additional criteria beyond basic licensing requirement for different levels of care, the layered regulation of foster homes run by CPAs becomes problematic when contrasted with the unilateral oversight of DFCS-approved foster homes. The Department's own foster homes are selected, approved, and regulated by the Department itself, with problems in foster homes often being addressed by case managers who personally know and have worked with the foster parents. Privatized foster care agencies, on the other hand, are regulated – often with a heavy hand – by the Office of Regulatory Services. Thus, an incident occurring within a private agency's foster home might result in a citation by ORS under its heightened scrutiny when the same incident occurring in a DFCS-approved foster home might not be pursued to the same end.

OCA believes that the differential treatment of "public" and "private" foster homes should be re-examined. When two foster homes are providing the same level of care, they should be licensed and evaluated on an equal basis using the same criteria. This principle reflects the spirit of the requirements in Section 471(a)(1) of the Social Security Act, which requires equal licensing requirements be established for all similarly-situated foster care providers.<sup>28</sup> OCA also suggests that the State consider whether a single, independent body should provide oversight of all foster care providers. By doing so, the State can ensure that private and public foster care providers are treated in a consistent manner with no possibility of conflicts of interest. As the State reviews its foster care system and reorganizes the Department of Human Resources, it should also consider whether a single independent agency should regulate all foster homes equally.

## **Conclusion**

The Office of the Child Advocate is proud to be an active participant in our state's system for protecting and treating our most vulnerable citizens. We appreciate the chance to serve our state's families, children, and taxpayers. We hope the elected and appointed leaders of our state will consider the work our agency has done in the past, consider it helpful and appropriate, and use it to improve our system. We also welcome your criticism, your insights, and your advice as we strive to make the work we do valuable.

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<sup>27</sup> See the Barton Clinic publication, "Georgia's Responsibility Toward Children in Foster Care," at <http://www.childwelfare.net/resources/FCResponsibility/>

<sup>28</sup> See the federal child welfare manual at [http://www.acf.hhs.gov/j2ee/programs/cb/laws\\_policies/laws/cwpm/policy\\_dsp.jsp?citID=26](http://www.acf.hhs.gov/j2ee/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=26)

*Appendix 1. Complaint Categories and Specific Complaint Issues for OCA Investigations*

<b>COMPLAINT CATEGORY</b>	<b>SPECIFIC COMPLAINT ISSUES</b>
<b>Case Management</b>	<ul style="list-style-type: none"> <li>• Case plan</li> <li>• Case worker caseload</li> <li>• Client/DFCS Communication</li> <li>• Confidentiality</li> <li>• Family team meeting</li> <li>• Failure to protect youth</li> <li>• Multiple Case workers</li> <li>• DFCS personnel</li> <li>• Case worker not meeting visitation requirements</li> <li>• Poor documentation</li> <li>• Services not provided</li> <li>• Services not provided in a timely manner</li> <li>• Timeliness of investigation</li> </ul>
<b>CPS (Child Protective Services)</b>	<ul style="list-style-type: none"> <li>• Failure to investigate referral</li> <li>• Failure to notify parent or child contact</li> <li>• Failure to remove child</li> <li>• Insufficient CPS investigation</li> <li>• Inappropriate case determination</li> <li>• Unnecessary removal of child</li> <li>• Response time of investigation</li> </ul>
<b>Permanency/Placement</b>	<ul style="list-style-type: none"> <li>• Placement of child (facility)</li> <li>• Placement of child (foster home)</li> <li>• Placement of child (relative)</li> <li>• Permanency</li> <li>• Reunification</li> <li>• Premature reunification</li> <li>• Emancipation</li> <li>• Too long in foster care</li> <li>• ICPC</li> <li>• Visitation</li> <li>• Home evaluation</li> <li>• Foster care per diem</li> <li>• Grievance, SMC</li> </ul>
<b>Miscellaneous</b>	<ul style="list-style-type: none"> <li>• DJJ</li> <li>• Child Support</li> <li>• Medicaid</li> <li>• Judicial</li> <li>• Eligibility</li> </ul>
<b>Legal</b>	<ul style="list-style-type: none"> <li>• Court order</li> <li>• Custody issues</li> <li>• State office decisions</li> <li>• Policy reform</li> <li>• Lack of criminal prosecution</li> <li>• Legal representation for child</li> </ul>
<b>CD/SI (Child Death/Serious Injury)</b>	<ul style="list-style-type: none"> <li>• Safety of siblings/children in the home</li> </ul>
<b>TPO (Temporary Protective Order)</b>	