

Georgia Office of the Child Advocate for the Protection of Children

2017 Annual Report

Tom C. Rawlings, Director State Office of the Child Advocate



OFFICE OF THE CHILD ADVOCATE

Nathan Deal Governor Tom C. Rawlings Director

January 9, 2018

By Hand Delivery

Hon. Nathan Deal Governor, State of Georgia

Hon. P. Harris Hines Chief Justice Georgia Supreme Court

RE: Transmittal of 2017 Annual Report Office of the Child Advocate Hon. Casey Cagle Lieutenant Governor Georgia State Senate

Hon. David Ralston Speaker Georgia House of Representatives

Dear Governor Deal, Chief Justice Hines, Lt. Gov. Cagle, and Speaker Ralston:

On behalf of the Office of the Child Advocate, I am pleased to provide you with this report of the work done by our office over the past year — work that each of you has made possible.

Over the past year, our office has worked in tandem with DFCS, the courts, and the child advocacy community to find ways of improving our state's effectiveness at combating child abuse and neglect. I remain encouraged at the extent to which leaders in our state show such a willingness to work across the lines of agencies and branches of government.

As the report reflects, we were able to initiate this year a multi-disciplinary training and networking conference that brought together juvenile court judges, child welfare attorneys, DFCS staff and leadership, and a host of professionals who work with children. It is this kind of cross-disciplinary cooperation that we continue to strive for in 2018.

We especially want to thank Governor Deal for the work of his Children's Mental Health Commission and commend its recommendations to the legislature. We also hope that, working together, we will find ways to expand the sharing of educational, medical, and

Office: 404-656-4200 7 Martin Luther King Jr. Drive, Suite 347, Atlanta, Georgia 30334 Fax: 404-656-5200

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law enforcement data among DFCS and our child-serving agencies so that we can better predict child abuse and prevent its recurrence.

Thank you for the leadership you show and for the opportunity to work with you.

Regards,

Tom C. Rawlings Director, OCA



Render Heard, Tifton Judicial Circuit (Juvenile Court Judge)

Laura Eubanks, Gwinnett County Public Schools (Social Worker)

Lisa Jones, Southwestern Judicial Circuit Judge (Juvenile Court Judge)

Jose Rodriquez, WellStar Kennestone Pediatric Associates (Pediatrician)

Brad Ray, Executive Director CASA (Court Appointed Special Advocates)

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OMBUDSMAN \'äm-,budz-mən \ [noun]: One that investigates, reports on, and helps settle complaints.

"The word "Ombudsman" can be found in Old Swedish as the word umbudsmann (accusative) and as umbuds man, meaning "representative." The modern meaning of the term emerged when the Swedish Parliament appointed an Ombudsman in 1809 to safeguard the rights of citizens through establishment of a supervisory agency independent of the executive branch."

OCA's Mission

When the Legislature created this agency in 2000, it intended the office to serve as an independent ombudsman for Georgia's child protection system. "It is the intent of the General Assembly that the mission of protection of the children of this state should have the greatest legislative and executive priority," the legislators declared. Thus, the agency's primary mission is "to protect the children of the State of Georgia and to assist and restore the security of children whose well-being is threatened by providing independent oversight of persons, organizations, and agencies responsible for providing services to or caring for children who are victims of child abuse and neglect or whose domestic situation requires intervention by the State."²

Mission

The mission [of the Georgia Office of the Child Advocate (OCA)] is to protect the children of the State of Georgia and to assist and restore the security of children whose well-being is threatened by providing independent oversight of persons, organizations, and agencies responsible for providing services to or caring for children who are victims of child abuse and neglect or whose domestic situation requires intervention by the state. O.C.G.A. Section 15-11-740 (b)

¹ http://federalombuds.ed.gov/federalombuds/ombuds_FAQs.html

² OCGA § 15-11-740 (b). The Act establishing our office is in Appendix A.

The statutes creating OCA envisioned that the bulk of our work would involve investigating and responding to complaints regarding children who are, or whose families have been, the subject of a DFCS report within the prior five years.³ Therefore, the bulk of our work involves responding to concerns lodged by parents, children, relatives, foster parents, and child welfare professionals regarding the way the agency or its contractors have handled a child protection case. We use these complaints and our resulting investigations not only to address the issue that may have arisen but also as a way of identifying trends within the child protection system. Then, carrying out our other main statutory mandates to collaborate with the child welfare community and to recommend changes in practice, we proactively take on projects designed to improve child safety, the child protection process, and outcomes for Georgia's abused and neglected children.4

Additionally, the General Assembly has entrusted to this agency a number of other statutorily-mandated roles. OCA monitors statewide the creation and implementation of local child abuse protocols, which are designed to ensure the appropriate multidisciplinary investigation and handling of child abuse cases, especially those involving sexual and serious physical abuse. We are also charged with training those local teams, and we annually update a statewide model child abuse protocol.⁵ The State Child Advocate serves as a member of the Statewide Child Fatality Review Committee, which is itself tasked with studying and finding ways to reduce the deaths of Georgia's children.⁶ Guardians ad litem who safeguard the best interests of children in juvenile court must be certified through training approved by the Office of the Child Advocate.7

³ OCGA §§ 15-11-741, 15-11-742.

⁴ OCGA § 15-11-743.

⁵ OCGA § 19-15-2; see Appendix C for the summary of our protocol training this past year.

⁶ OCGA § 19-5-4; for more information on the Child Fatality Review Committee, visit https://gbi.georgia.gov/CFR

⁷ OCGA § 15-11-104 (f).

2017 Changes at OCA

OCA's 2017 year opened with the appointment by Governor Deal of a new State Child Advocate, Tom Rawlings, who returned to the position in which he served under Governor Sonny Perdue from 2007-2010. Ashley Willcott, who had served as State Child Advocate from 2013-2016, returned to private child welfare law practice but remains very involved with OCA as the lead attorney on the Cold Case Project.⁸ Director Rawlings brought in a new Deputy Director, Rachel Davidson, a skilled child welfare



Davidson

attorney who previously represented children in dependency proceedings and served in critical roles at the State Division of Family and Children Services, including a position as liaison between the agency and the juvenile courts. Diana Summers, whose expertise lies in administration, grants, and data management and analysis, rounded out the new leadership team.



Rawlings

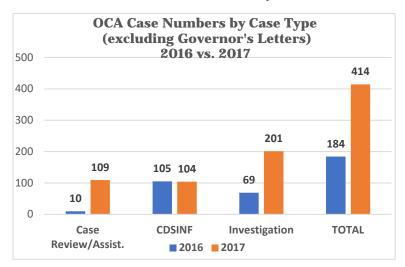
With the exception of new leadership, however, OCA's experienced team of investigators remained in place: Chuck Pittman, Vickie White, Ryan Sanford, Renee Moore, and Shantelle

Whitehead.

Responding to Complaints and Concerns

Concerns and complaints from the public come to OCA in a number of ways. The

public may call us at (404) 656-4200 and speak with our intake staff to file a complaint, and many of our reports come through our online complaint form. 9 Additionally, we receive calls from judges, legislators, and agency officials who have concerns about a case or who call on behalf of a child or constituent. Our agency is also notified of letters, emails, and calls that Governor Deal's office receives and that are most often handled by DFCS' internal constituent services staff. Should these concerns not be



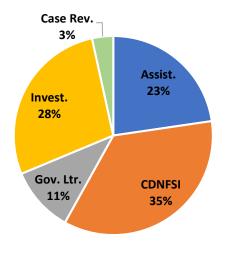
⁸ See Cold Case Project discussion, pp. 6-7.

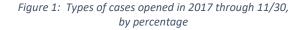
⁹ https://oca.georgia.gov/webform/request-oca-assistance-or-investigation

resolved within DFCS, we from time to time will undertake an investigation related to the concern.

Between January 2017 and the end of November 2017, OCA opened a total of 291 new cases (see figures 1 and 2). Many of these cases (103, or 35%) involved situations in which OCA reviewed a death, near fatality, or serious injury that occurred to a child whose family had involvement with DFCS within the five years prior to the significant incident. We review these cases to determine whether the agency's prior involvement with the family was sufficient and whether the agency could reasonably have taken measures to prevent a subsequent incident of abuse or neglect. For several years, OCA has facilitated the group of DFCS staff, service providers, and other professionals who review these cases.

In the majority of these serious incidents, we find the child's death or injury to be unrelated to the family's prior involvement with the child protection agency. For example, DFCS may become involved with the family of a medically fragile newborn not due to allegations of abuse or neglect but rather because the family needs additional support to care for that child. If the child later dies from the medical condition, the case is one that DFCS and OCA will consider for possible review.





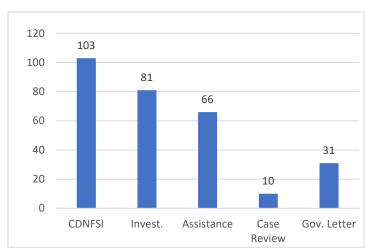


Figure 2: Number and type of cases opened by OCA in 2017 (through 11/30)

During the first 11 months of 2017, OCA responded to a number of complaints by investigating, providing a constituent with information and assistance, or by simply

reviewing the case to ensure all was well. In its review of complaints and cases, OCA attempts to determine whether there were problems in the implementation of child protection policy or errors in practice. Of the 241 cases we opened and closed through November 30, 2017, we found policy violations in 10% and noted child welfare practice deficiencies in 24%. The leading issues we found were problems in providing adequate assessment of a child or family's situation and problems in providing adequate services to families. The most common complaints we received from the public involved insufficient investigations of child abuse complaints and concerns regarding child placement.

Under its new director, OCA has put an emphasis on timely resolution of complaints and on cutting down the amount of time a case remains open. As a result of this new focus, we were able to cut our caseload from 417 open cases at the beginning of January to 231 open cases at the beginning of December. The amount of time our cases remain open reflects their level of difficulty. When we are reviewing a file or reviewing a child death or serious injury, we find it takes between 11 and 17 days to finalize our assessment. Cases in which we are providing assistance to a family, a provider, a child, or the public remain open around a month. Investigations, in which we are digging more deeply into the case to find the cause for an alleged problem and a solution to that problem, remain open for an average of two months.



Governor Deal with incoming and outgoing OCA Staff at Director Rawlings' Swearing-in, January 2017

Major Projects 2017

As a small ombudsman agency, OCA cannot (and should not) attempt to involve itself in every aspect of Georgia's child protection and child welfare system. Rather, we must prioritize efforts that we believe will have the greatest impact to improve the system, its efficiency, and its effectiveness. In 2017, we continued or began a number of projects through which we could bring our expertise to bear to improve outcomes for children and which involved working across disciplines and agencies to improve Georgia's child protection system. These included:

- The Cold Case Project;
- The Peer Review Project;
- The Summit, Georgia's Child Protection Conference; and
- Child Abuse Protocol Development and Training.

The Cold Case Project

Since 2009, OCA has collaborated with the Supreme Court of Georgia's Committee and DFCS to review and resolve some of the most difficult cases in our child welfare system: those in which children have lingered in foster care for long periods of time without returning to a safe home or finding a safe, stable, permanent family.

The "Cold Case" Project ("CCP") — so named because it addresses children whose search for permanent, safe, stable families has grown "cold" and whose cases need an injection of new heat and energy — is driven by a software algorithm that mines DFCS' database to find those children who have been in foster care for long periods of time and who are likely to age out of the system without permanency. CCP Fellows — experienced child welfare attorneys — then review the cases, schedule meetings or permanency roundtables with all DFCS staff, attorneys, therapists and the children and families involved, and search for ways to ensure that children do not age out of foster care without a permanent family setting.

A COLD CASE PROJECT SUCCESS STORY

Cold Case Project fellows worked with "Tim," a teenager who had spent 54 months in care, had gone through 11 different placements, and who had significant behavioral health issues.

Although both parents' rights had been terminated, Tim's father remained in contact with him, and Tim wanted to return to his father.

CCP staff worked to strengthen the bond between Tim and his father, ensuring that the father had special training to learn how to address Tim's needs.

The Court reviewed the case and reinstated the legal relationship between Tim and his father, restoring a family for Tim.

The project is led by Ashley Willcott, and this year's fellows were Kristi Lovelace, Amanda Dean, Kellie Rogers, Diana Rugh-Johnson, Karlise Grier, Rosalind Zolicoffer, Jane Okrasinki, Mary Hermann, Vicky Wallace, and Michelle Vereen.

In 2017, CCP staff and fellows reviewed more than 235 new files and conducted over 160 "roundtable" staffings. In past years, we have found this work to substantially increase positive outcomes for children. The 2017 Cold Case Project Report will be issued in 2018, and the 2016 report is available online.¹⁰

The Peer Review Project

In 2017, OCA continued a valuable project we have undertaken for several years to improve juvenile court processes and outcomes. Working with Jerry Bruce (a former juvenile court judge who serves as Program Attorney for the Supreme Court's



Peer Review Counties 2017

Committee on Justice for Children) and a number of highly-experienced and certified child welfare attorneys, OCA in 2017 visited juvenile courts in 17 different jurisdictions. At OCA, we are cognizant of the fact that protecting a child's rights to be heard, to be protected, and to live in a safe, stable family is the vital role of the juvenile courts and the attorneys who represent parties in those courts. Our Peer Review Project has, therefore, focused on improving the court processes that create those outcomes.

OCA's experts were especially interested in observing how different jurisdictions address the rights of children involved in dependency and termination of parental rights cases to have both a court-appointed attorney to represent their wishes¹¹ and a guardian ad litem and/or

CASA to represent their best interests. ¹² We also made efforts to note the different methods by which courts consider the participation rights of children; how different courts receive evidence; whether children and foster parents were notified of hearings; ¹³ and the extent to which parents, children, and DFCS were represented by legal counsel during these important proceedings.

¹⁰ https://sites.google.com/site/gacoldcaseannualreport2016/

¹¹ OCGA § 15-11-103.

¹² OCGA § 15-11-104.

¹³ See OCGA § 15-11-109.

While full details of the 2017 findings are available in Appendix B, a few findings from our observations stand out. Some courts, we found, are not ensuring the child is present for hearings affecting him or her and has the ability to share his or her concerns. 14 Having the child present is especially important for youth and older children. At OCA, we often hear complaints from young adults who were in foster care that they never felt included in the court decisions affecting their lives. We also found

that some courts are not holding the child protection agency's feet to the fire when it comes to the requirement that DFCS diligently and continually search for relatives who might be able to take custody of a child. 15 Our Peer Review observations have formed the basis for ongoing trainings that OCA and the Supreme Court's Committee on Justice for Children provide to child welfare attorneys and other court partners.

The Summit, Georgia's Child Protection **Conference**



Brooke Silverthorn of the National Association of Counsel for Children spoke on the ethics of child representation.

In what we hope will be an annual event that will grow in both size and impact,



Governor Deal addresses the Summit attendees

OCA teamed up with DFCS, the Georgia Supreme Court, and a number of other partners to host a multidisciplinary child protection and child welfare conference November 27-29, 2017. Held at the Intercontinental Hotel in Atlanta, the conference was attended by almost 500 child welfare professionals including front-line case managers, juvenile court judges, attorneys, and medical personnel from all around Georgia. The training agenda for the conference focused on the intersection between law and child welfare practice and featured a number of

inspiring national speakers including Judge Michael Nash from Los Angeles and Amelia Franck Meyer.

One of the highlights of the Summit was the presentation of videos featuring the

¹⁴ OCGA § 15-11-19 (a).

¹⁵ OCGA § 15-11-211.

work of case managers and judges around the State. In addition to providing training, the Summit provided motivation and reinforcement for those who are doing the difficult work of protecting children night and day. OCA believes this sort of multi-disciplinary training, in which front-line workers get to spend time networking and sharing with juvenile court judges and attorneys, is an excellent way to improve our state's system.

Presentations and videos from the Summit are available on OCA's website at https://oca.georgia.gov/georgia-child-welfare-summit-2017.

Child Abuse Protocol Training and Development

As it has done for many years now, OCA continued in 2017 to work with a number of partners including the state's prosecutors, Child Advocacy Centers, Prevent Child Abuse Georgia, DFCS, Law Enforcement, GBI, and medical professionals to

improve our Statewide Child Abuse Protocol. Jodi Spiegel, former OCA Deputy Director, and former OCA Director Ashley Willcott continued to work with our agency by providing child abuse protocol trainings across the state and by convening a "mini-summit" of 58 child welfare professionals on September 22nd to revise and update the Statewide Protocol.

The updated draft has been submitted to OCA and is in the proofing stage at the time of this report. The draft will be reissued to contributors for final edits in January 2018. When the document is finalized, the 2017 Statewide Model Child Abuse Protocol will be distributed across the state as a tool to assist each jurisdiction update their own protocols. The model protocol will also be posted on the OCA website as a reference resource.



Jodi Spiegel leads the Child Abuse Protocol Mini-Summit

A full evaluation of the Protocol Project is available in Appendix C.

Other Projects and Initiatives

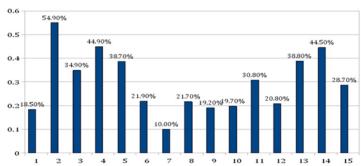
In addition to these major projects, OCA staff worked diligently across agencies and professions in 2017 to improve child welfare law, policy, and practice. Here are just a few of the efforts we made to improve Georgia's system of protecting its most vulnerable children:



- 1. Training nurses, medical providers, DFCS personnel, and other professionals on how to better collaborate to keep children safe. This work continues. OCA has developed a number of protocols for these professionals to follow to ensure the appropriate investigation of serious physical injury cases and has convened a working group to address care for newborns who are medically fragile or who are affected by substance abuse. To date, we have conducted trainings in Augusta, Atlanta, and Columbus as well as site visits in Savannah.
- 2. Working to Keep Children in Foster Care Close to Home

OCA Deputy Director Rachel Davidson served in an integral role as part of an ongoing project to keep children in foster care close to the homes from which they were removed. As the chart nearby shows, children in DFCS custody are too often placed in foster homes far from their families, making it more difficult for them to maintain stability and attachments to school, friends, activities, their faith community, and extended family support. As part of an effort to achieve permanency for youth in

PERCENT OF CHILDREN PLACED OUTSIDE OF THEIR REGIONS (APRIL 2014)



DFCS makes every attempt to place children as close to their home community and school as possible. Region 3 is the 6th highest in the state with 35% of children placed outside of the region, and Region 5 is the 4th highest with 39%. This suggests that both regions are challenged in developing placement resources within their own region.

foster care and reduce the trauma of removal and placement changes, DFCS has made keeping children in local homes a priority, and OCA continues to work with DFCS and court leaders to implement this vision.

3. Developing Guidelines for Working with Disabled Parents Throughout 2017, OCA staff has helped lead a working group of academics from Emory Law, judges, attorneys, DFCS leadership, and other professionals to address a growing concern: the proper handling of dependency cases involving parents who have severe developmental and cognitive disabilities and mental illness. Under the Americans with Disabilities Act (ADA), states must make additional efforts to help these parents raise their own children. To that end, OCA has worked with the Barton Child Law and Policy Center at Emory



University to create a handbook that will help judges, attorneys, and case managers better address the needs of these parents while keeping their children safe and connected with family. That guidebook will be published in early 2018.

4. Working with Youth in Foster Care

At OCA, we strongly believe that youth in foster care should be listened to and treated with respect. In 2017, OCA staff have regularly worked with DFCS and its providers as well as directly with these youth to ensure teens in foster care, as well as older youth who have remained in care past age 18, are able to fully participate in the decisions that will affect their futures. It is a legal and moral imperative that we prepare these youth to become responsible adults by providing them with proper educational opportunities, life skills, drivers' lessons, financial education, and the support they need as they heal from trauma and when they make the mistakes that we have all experienced and from which we learn to be healthy and productive adults.

5. Fighting Sex Trafficking

OCA's staff regularly participate in a number efforts to combat sex trafficking and sexual exploitation of children and serve on committees that are engaged in fighting this scourge. In September, OCA investigator Renee Moore had the opportunity to intervene herself to rescue a teenaged girl from sex trafficking. She writes:

"I reviewed a case involving a seventeen-year-old runaway. During the course of the investigation, OCA discovered this child was being sex trafficked. OCA reached out to collaborative partners to begin what became an exhaustive search to find this child. Due to the efforts of many, this child was found and resources obtained to try and begin the healing process for this child. While attempting to change the course this child was on it was discovered this child had suffered a long history of abuse.

I spent many hours wondering what could have been done differently the conclusion I came to is sometimes we give up because we think there is nothing else that can be done. What I discovered is that no matter what age the child, they need to know we are not giving up on them. I also learned that whether you are law enforcement, OCA, DFCS, a private provider or a community resource, we are all focused on ensuring each child is safe and



protected and will take whatever course of action necessary to ensure we have done everything we could.

We do not see success every day but we move forward every day in this work to try and make that difference in a child's life. While everyone has heard the adages of how hard the work is and sometimes wonder if it is all worth it.....I can tell you it is worth every moment!!!!!"

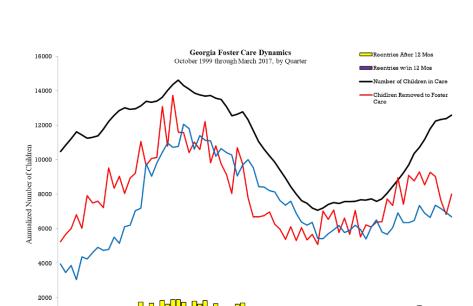
6. Addressing the Needs of Runaway Children

Georgia has responsibilities to protect victims of child abuse and neglect, even if those children and youth we are serving claim not to want our help. Often, we find that victims of child abuse often have emotional or behavioral issues that drive them to run away from foster care. At the same time, these children who do run away are often at high risk for exploitation and sex trafficking. At OCA, we developed during 2017 additional guidelines and protocols for juvenile courts and DFCS to use to improve all of our efforts to locate, assist, and protect children who have run away from care.

The State of Child Welfare: **Recommendations for 2018**

All public child protection and child welfare systems worldwide are under stress. Workers who go into this field with the best of intentions often burn out from dealing with the trauma they see. As a result, public child protection systems often have high worker turnover. Too often, when a child who should be under the system's protection dies, the public has a tendency to blame the system itself, and this public pressure often results in changes to agency leadership and sudden shifts in policy, law, and practice.

Georgia has itself experienced these types of issues since OCA's creation, which itself was spurred in part by the tragic death of a child who had passed through our child protection system.



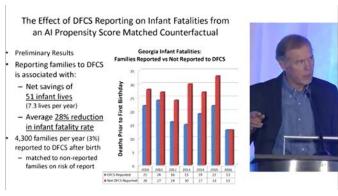
As the chart above shows, since 2000 we have had spikes and troughs in the number of children in care. Right now, we are experiencing another spike. It is likely that this increase in the number of children placed in foster care has resulted from a combination of the following factors:

- 1. The implementation of a statewide centralized intake system for child abuse reporting (1-855-GACHILD), which has resulted in a significant increase in the number of reports of child maltreatment the State receives each month;
- 2. The debilitating effects of the opioid crisis, which has produced a significant number of addicted parents who are not able to care for their children and whose addictions cannot be quickly treated and resolved; and
- 3. To some extent, a natural leveling of the system, as our State's leadership has focused more on keeping children safe. It is likely that prior to 2010, the number of children in foster care was lower than might have been expected.

Governor Deal, working with former DFCS Director Bobby Cagle, has responded to these increases by making significant investments in our child protection workforce, including providing significant pay increases for new front-line workers. OCA is pleased not only with those reforms but also with improvements DFCS is implementing in the way the agency recruits, trains, mentors, and retains its workforce. In our opinion,

front-line CPS workers who work night and day in dangerous situations deserve the same respect and honor that we accord firefighters, policemen, and other emergency responders.

One of the key indicators of the success of our system is the number of children who are identified as having suffered abuse or neglect who remain free from additional abuse or neglect. Between October 2016 and September 2017, 96.3% of children who were found to have suffered maltreatment did not suffer additional maltreatment during the following six months. This result compares very favorably to national standards. Another key indicator of the system's health is how quickly we are moving our children in foster care to safe, stable, permanent homes through reunification, placement with relatives, or adoption. In Georgia, for the 12 months ending in September 2017, DFCS reunited 57% of children in foster care with family or relatives within 12 months, with those children remaining in care for a median length of time of 10 months. We do have some work to do in assuring that children who must have a new adoptive family are moved along that path quickly; those children remained in foster care for a median length of time of almost 31 months.



Andy Barclay's "Lives Saved" Presentation at The Summit

Although the public often hears of children who may have not been protected by state child protection systems, in 2017 OCA and its partners at DFCS, Public Health, and the Georgia Supreme Court Committee on Justice for Children were able to support a project that has demonstrated for the first time that DFCS involvement does, in fact, save children's lives. Andy Barclay, a child welfare statistician, was able to compare two demographically nearly-identical

groups of families: one that had experienced DFCS involvement, and another that had not. His conclusion, supported by the data, is that DFCS involvement reduced child deaths by almost 40%. ¹⁶ In 2018, we hope to expand on these kinds of studies.

Two other bright spots on which we expect to see improvement by the state's child welfare system in 2018 are in the areas of behavioral health care for children and educational achievement for children in foster care. The first improvement we expect will come from Governor Deal's efforts to implement the recommendations of his

¹⁶ Andy Barclay's "Lives Saved" presentation is available at https://www.youtube.com/watch?v=DD7-BB7uOls&feature=youtu.be



Commission on Children's Mental Health.¹⁷ Among its recommendations, which we hope the General Assembly will follow, are to increase funding for school-based mental health services for children and to create and fund additional specialized therapeutic foster care services for children with significant mental health needs. The unfortunate fact is that our behavioral health system and our child protection system often serve the same children: those who have been yelled at continually, physically abused, who have witnessed domestic violence, or who have lived not knowing whether they are loved or cared for. By improving mental health services for all children, we can improve the chances they will not enter foster care and will grow into healthy adults.

The second area to highlight is DFCS' recent efforts to boost graduation rates among children in foster care. Nationally, children in foster care have low graduation rates in part because of the trauma they have experienced that has hampered their ability to get a stable education. We have an obligation to ensure that once those children are in a stable foster home, they are empowered and supported to graduate from high school and take advantage of opportunities to pursue further technical or college degrees. The Multi-Agency Alliance for Children, DFCS, OCA and others have recently begun a collaborative project that will focus on improving these educational outcomes.

OCA has, in its partnership for child protection, offered throughout the year policy and practice recommendations to DFCS when we believed the agency's work was not carried out to its potential. In addition, we recommend for 2018 that the State – not limited to DFCS but including courts and other child-serving agencies -- focus on the following issues:

1. Increase data for better decision-making

DFCS should work with the Department of Public Health, the Department of Behavioral Health and Developmental Disabilities, the Department of Juvenile Justice, the Department of Community Health, and other state agencies to automate the provision of data that can help DFCS "flag" dangerous situations. For example, when DFCS is determining the risk of danger to a child about whom a child abuse complaint has been made, it should have the ability automatically to pull that child's medical records as well as his or her parents' records related to substance abuse and mental health. Many of these records are already kept in electronic form.

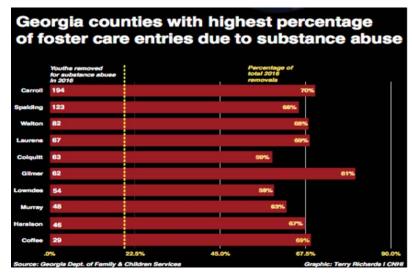
¹⁷ The full Commission report, released on December 11, 2017, can be found on OCA's website at https://oca.georgia.gov.



Likewise, if DFCS has a report on a child but cannot find the family despite a diligent search, emergency rooms and law enforcement personnel should have a way to alert DFCS if they encounter the family.

2. Improve handling of situations involving newborns affected by substance use

 Pursuant to the federal Comprehensive Addiction and Recovery Act of 2016, states are required to identify and assess children who are born "affected" by drugs, whether those drugs are properly prescribed or are illegal street drugs. DFCS has taken the lead on receiving reports of drug-exposed children, requesting the parental substance abuse



assessment, and working with providers such as Babies Can't Wait to implement the "plan of safe care" required by this federal law. In OCA's experience, however, there remain a number of obstacles to successful implementation, including:

- Some hospitals and healthcare providers are not notifying the agency of children born drug-exposed, thwarting the agency's ability to help these families.
- There is a lack of coordination among the various agencies and providers who are charged with assessing the mother's substance abuse issues, designing a plan to help her while keeping the child safe, and implementing services.

OCA has formed a working group to address these issues and recommends that all state health care agencies and providers make the identification, assessment, and treatment of drug-exposed newborns a priority.

Conclusion

All of us at OCA continue to look for ways that we can positively impact our state's

system for protecting children. We understand that this responsibility is not that of one agency or even of government alone; rather, it requires us to work humbly in partnership with all of those who have made child protection the focus of their work.

Appendices

Appendix A: Georgia Child Advocate for the Protection of Children Act

O.C.G.A. §15-11-740.

- (a) This article shall be known and may be cited as the "Georgia Child Advocate for the Protection of Children Act."
- (b) In keeping with this article's purpose of assisting, protecting, and restoring the security of children whose well-being is threatened, it is the intent of the General Assembly that the mission of protection of the children of this state should have the greatest legislative and executive priority. Recognizing that the needs of children must be attended to in a timely manner and that more aggressive action should be taken to protect children from abuse and neglect, the General Assembly creates the Office of the Child Advocate for the Protection of Children to provide independent oversight of persons, organizations, and agencies responsible for providing services to or caring for children who are victims of child abuse and neglect or whose domestic situation requires intervention by the state. The Office of the Child Advocate for the Protection of Children will provide children with an avenue through which to seek relief when their rights are violated by state officials and agents entrusted with their protection and care.

O.C.G.A. §15-11-741.

As used in this article, the term:

- (1) "Advocate" or "child advocate" means the Child Advocate for the Protection of Children established under Code Section 15-11-742.
- (2) "Agency" shall have the same meaning and application as provided for in paragraph (1) of subsection (a) of Code Section 50-14-1.
- (3) "Child" or "children" means an individual receiving protective services from DFCS, for whom DFCS has an open case file, or who has been, or whose siblings, parents, or other caretakers have been, the subject of a report to DFCS within the previous five years.

O.C.G.A. §15-11-742.

(a) There is created the Office of the Child Advocate for the Protection of Children . The Governor, by executive order, shall create a nominating committee which shall consider nominees for the position of the advocate and shall make a recommendation to the Governor. Such person shall have knowledge of the child welfare system, the juvenile justice system, and the legal system and shall be qualified by

training and experience to perform the duties of the office as set forth in this article.

- (b) The advocate shall be appointed by the Governor from a list of at least three names submitted by the nominating committee for a term of three years and until his or her successor is appointed and qualified and may be reappointed. The salary of the advocate shall not be less than \$60,000.00 per year, shall be fixed by the Governor, and shall come from funds appropriated for the purposes of the advocate.
- (c) The Office of the Child Advocate for the Protection of Children shall be assigned to the Office of Planning and Budget for administrative purposes only, as described in Code Section 50-4-3.

The advocate may appoint such staff as may be deemed necessary to effectively fulfill the purposes of this article, within the limitations of the funds available for the purposes of the advocate. The duties of the staff may include the duties and powers of the advocate if performed under the direction of the advocate. The advocate and his or her staff shall receive such reimbursement for travel and other expenses as is normally allowed to state employees from funds appropriated for the purposes of the advocate.

- (d) The advocate shall have the authority to contract with experts in fields including but not limited to medicine, psychology, education, child development, juvenile justice, mental health, and child welfare as needed to support the work of the advocate, utilizing funds appropriated for the purposes of the advocate.
- (e) Notwithstanding any other provision of state law, the advocate shall act independently of any state official, department, or agency in the performance of his or her duties.
- (f) The advocate or his or her designee shall be a member of the Georgia Child Fatality Review Panel.

O.C.G.A. §15-11-743.

The advocate shall perform the following duties:

- (1) 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;
- (2) Refer complaints involving abused children to appropriate regulatory and law enforcement agencies;
- (3) Report the death of any child to the chairperson of the review committee, as such term is defined in Code Section 19-15-1, for the county in which such child resided at the time of death, unless the advocate has knowledge that such death has been reported by the county medical examiner or coroner, pursuant to Code Section 19-15-3, and to provide such committee access to any records of the advocate relating to such child;

- (4) Provide periodic reports on the work of the Office of the Child Advocate for the Protection of Children, including but not limited to an annual written report for the Governor and the General Assembly and other persons, agencies, and organizations deemed appropriate. Such reports shall include recommendations for changes in policies and procedures to improve the health, safety, and welfare of children and shall be made expeditiously in order to timely influence public policy;
- (5) Establish policies and procedures necessary for the Office of the Child Advocate for the Protection of Children to accomplish the purposes of this article, including without limitation providing DFCS with a form of notice of availability of the Office of the Child Advocate for the Protection of Children. Such notice shall be posted prominently, by DFCS, in DFCS offices and in facilities receiving public moneys for the care and placement of children and shall include information describing the Office of the Child Advocate for the Protection of Children and procedures for contacting such office; and
- (6) Convene quarterly meetings with organizations, agencies, and individuals who work in the area of child protection to seek opportunities to collaborate and improve the status of children in Georgia.

O.C.G.A. §15-11-744.

- (a) The advocate shall have the following rights and powers:
 - (1) To communicate privately, by mail or orally, with any child and with each child's parent, guardian, or legal custodian;

To have access to all records and files of DFCS concerning or relating to a child, and to have access, including the right to inspect, copy, and subpoena records held by clerks of the various courts, law enforcement agencies, service providers, including medical and mental health, and institutions, public or private, with whom a particular child has been either voluntarily or otherwise placed for care or from whom the child has received treatment within this state. To the extent any such information provides the names and addresses of individuals who are the subject of any confidential proceeding or statutory confidentiality

provisions, such names and addresses or related information that has the effect of identifying such individuals shall not be released to the public without the consent of such individuals. The Office of the Child Advocate for the Protection of Children shall be bound by all confidentiality safeguards provided in Code Sections 49-5-

- 40 and 49-5-44. Anyone wishing to obtain records held by the Office of the Child Advocate shall petition the original agency of record where such records exist;
- (2) To enter and inspect any and all institutions, facilities, and residences, public and private, where a child has been placed by a court or DFCS and is currently residing. Upon entering such a place, the advocate shall notify the administrator or, in the absence of the administrator, the person

in charge of the facility, before speaking to any children. After notifying the administrator or the person in charge of the facility, the advocate may communicate privately and confidentially with children in the facility, individually or in groups, or the advocate may inspect the physical plant. To the extent possible, entry and investigation provided by this

Code section shall be conducted in a manner which will not significantly disrupt the provision of services to children:

- (3) To apply to the Governor to bring legal action in the nature of a writ of mandamus or application for injunction pursuant to Code Section 45-15-18 to require an agency to take or refrain from taking any action required or prohibited by law involving the protection of children;
- (4) To apply for and accept grants, gifts, and bequests of funds from other states, federal and interstate agencies, independent authorities, private firms, individuals, and foundations for the purpose of carrying out the lawful responsibilities of the Office of the Child Advocate for the Protection of Children;
- (5) When less formal means of resolution do not achieve appropriate results, to pursue remedies provided by this article on behalf of children for the purpose of effectively carrying out the provisions of this article; and
- (6) To engage in programs of public education and legislative advocacy concerning the needs of children requiring the intervention, protection, and supervision of courts and state and county agencies.
- (b) (1) Upon issuance by the advocate of a subpoena in accordance with this article for law enforcement investigative records concerning an ongoing investigation, the subpoenaed party may move a court with appropriate jurisdiction to quash such subpoena.
 - (2) The court shall order a hearing on the motion to quash within five days of the filing of the motion to quash, and the hearing may be continued for good cause shown by any party or by the court on its own motion. Subject to any right to an open hearing in contempt proceedings, such hearing shall be closed to the extent necessary to prevent disclosure of the identity of a confidential source; disclosure of confidential investigative or prosecution material which would endanger the life or physical safety of any person or persons; or disclosure of the existence of confidential surveillance, investigation, or grand jury materials or testimony in an ongoing criminal investigation or prosecution. Records, motions, and orders relating to a motion to quash shall be kept sealed by the court to the extent and for the time necessary to prevent public disclosure of such matters, materials, evidence, or testimony.
- (c) The court shall, at or before the time specified in the subpoena for compliance therewith, enter an order:
 - (1) Enforcing the subpoena as issued;
 - (2) Quashing or modifying the subpoena if it is unreasonable and oppressive; or

(3) Conditioning enforcement of the subpoena on the advocate maintaining confidential any evidence, testimony, or other information obtained from law enforcement or prosecution sources pursuant to the subpoena until the time the criminal investigation and prosecution are concluded. Unless otherwise ordered by the court, an investigation or prosecution shall be deemed to be concluded when the information becomes subject to public inspection pursuant to Code Section 50-18-72. The court shall include in its order written findings of fact and conclusions of law.

O.C.G.A. §15-11-745.

- (a) No person shall discriminate or retaliate in any manner against any child, parent, guardian, or legal custodian of a child, employee of a facility, agency, institution or other type of provider, or any other person because of the making of a complaint or providing of information in good faith to the advocate or willfully interfere with the advocate in the performance of his or her official duties.
- (b) Any person violating subsection (a) of this Code section shall be guilty of a misdemeanor.

O.C.G.A. §15-11-746.

The advocate shall be authorized to request an investigation by the Georgia Bureau of Investigation of any complaint of criminal misconduct involving a child.

O.C.G.A. §15-11-747.

- (a) There is established a Child Advocate Advisory Committee. The advisory committee shall consist of:
 - (1) One representative of a not for profit children's agency appointed by the Governor;
 - (2) One representative of a for profit children's agency appointed by the Lieutenant Governor;
 - (3) One pediatrician appointed by the Speaker of the House of Representatives;
 - (4) One social worker with experience and knowledge of child protective services who is not employed by the state appointed by the Governor;
 - (5) One psychologist appointed by the Lieutenant Governor;
 - (6) One attorney from the Children and the Courts Committee of the State Bar of Georgia appointed by the Speaker of the House of Representatives; and
 - (7) One juvenile court judge appointed by the Chief Justice of the Supreme Court.

Each member of the advisory committee shall serve a two-year term and until the appointment and qualification of such member's successor. Appointments to fill vacancies in such offices shall be filled in the same manner as the original appointment.

(b) The advisory committee shall meet a minimum of three times a year with the advocate and his or her staff to review and assess the following:

- (1) Patterns of treatment and service for children;
- (2) Policy implications; and
- (3) Necessary systemic improvements.

The advisory committee shall also provide for an annual evaluation of the effectiveness of the Office of the Child Advocate for the Protection of Children.

Appendix B: Peer Review Evaluation 2017

Background and Purpose:

The Peer Review Project works to improve legal representation for children in child welfare cases. Child welfare attorneys visit juvenile courtrooms across the state for the purpose of observing child attorneys and guardians ad litem, and to note the tone set by judges for dependency hearings. Utilizing funding from the Judicial Council's Administrative Office of the Courts of Georgia, the Office of the Child Advocate contracted with several attorneys and partnered in-kind with prominent child welfare advocates to conduct the 2017 Peer Review Project. Observations were scheduled for seventeen (17) different jurisdictions and took place from April through June.

The findings in this report include evaluations of 51 cases across 11 counties (Bulloch, Butts, Columbia, Fayette, Gilmer, Habersham, Henry, Lowndes, Marion, McDuffie and Upson). Peer Review was also conducted in Crisp County where the reviewer observed 6 cases; however all observations detailed case specifics rather than attorney performance and could not be included. Reviewers visited five (5) additional counties (Barrow, Burke, Cobb, Randolph and Coweta) that have not been included; no notes have been received for these observations to date. A final Peer Review was scheduled for Coffee County, but was cancelled due to inclement weather; it will be rescheduled at a later date.

Reviewers were provided forms detailing specific case information they were to note during their observations. Reviewers were also provided forms to collect overall information on how the courts conducted dependency hearings in each jurisdiction. However, many questions were frequently left unanswered, limiting the extent of a standardized evaluation across the Peer Review sites. It may have been that the specific hearings observed did not mesh well with the data collection form, or that some reviewers did not understand the importance of collecting information as specified on the form. This issue should be further investigated and resolved prior to scheduling additional reviews.

Summary – Overall Court Observations:

ICWA and immigration are extremely rare and considered non-issues in the jurisdictions reporting. Relative strengths and weaknesses are noted across sites as follows:

Strengths

- Father participation (75%)
- ✓ Visitation (75%)

Weaknesses

- Child participation (30%)
- **✗** Diligent search (50%)
- **➤** Permanency efforts (57%)

Only one county (Columbia) uses CPRS and about one-half uses fill-in-the blank orders. The majority (two-thirds) uses third party custody, but only after family members and by agreement of all parties.

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The majority of the open-ended comments were about the lack of legal findings and lack of reasonable efforts findings. As one reviewer noted, "There were no findings of fact or conclusions of law made by the court in any of the cases." It was noted that several jurisdictions do not use CASA, and issues were noted with the failure to submit reports and other documents into evidence. "Another difficulty was the general failure of the court to comply with rules of evidence," was one observation.

The most common training suggestions address child advocacy and basic trial skills. "The attorneys need basic training in juvenile-court practice and procedure, as well as in basic trial and advocacy skills."

<u>Summary – Individual Case Observations:</u>

Of the 51 cases for which notes were received, only 27 (53%) note the length of the hearings. The average hearing lasted 18 minutes, and one-third lasted ten minutes or less. "The hearings were handled in summary fashion . . . the parties were not seated at their tables, but rather gathered around the podium."

In the majority of cases observed, the child was represented by an attorney serving in a dual role (76%); in only 10% of cases were both child attorneys and GALs assigned. As was suggested in the overall comments, there was no CASA involvement in more than half the cases.

Presence of children in the courtroom is the exception rather than the rule; children were present at less than one-quarter of the hearings. Their absence is as likely to be waived as not, with age being the most common reason for waiving the child's presence at court. In the few cases in which the child was present, engagement was low. Neither judges nor attorneys were engaged with the children who were present at court. Interaction was observed in less than one-third of the cases.

It is important to note that non-response to specific measures of child attorney and GAL performance was extremely high, ranging from 24% to 63% depending upon the particular



question. With that in mind, the percentages reported below are based on total answers received (i.e., excluding non-response).

In most cases, the attorney acted in a dual role. As the child attorney, the attorney seemed prepared for court in only slightly more than half the cases. Overall, child attorneys did not perform well on any of the measures collected. It is especially alarming that only one-quarter demonstrated knowledge about the law.

Child Attorney demonstrated evidence of:

Hearing preparation	57%
Commitment to visitation	52
Presenting the child's position	50
Commitment to expediting permanency	38
Knowledge of child's health/special needs	37
Knowledge of state/federal law	28

Attorneys in the guardian ad litem role performed as poorly, or worse. Only two in five GALs demonstrated any knowledge of child safety, and written reports were virtually non-existent.

GAL:

Demonstrated knowledge of child safety	42%
Made efforts to expedite permanency	36
Address best interest prongs	27
Submitted written report	6

General comments made by reviewers most frequently centered on:

- All parties were not represented
 - "Mom asked to apply for counsel, but the case went forward anyway"
 - "There was no inquiry as to whether mom wanted an attorney."
- Lack of child contact by GALs
 - "[the GAL] was well-informed about the child, however has no personal contact"
 - "First time GAL saw kids was recently case is over six months old"
- Low attorney participation during hearings

- "The judge asked all the questions from the bench and all the attorneys responded with 'yeses' and the occasional comment"
- "The child attorney asked no questions."

<u>Summary – Concerns:</u>

In spite of the low response rate on data collection forms, it does appear that both systemic issues and attorney skill levels are affecting the quality of child representation in several jurisdictions. Many judges are directing hearings from the bench, asking questions of witnesses who have not been sworn in and referring to documents not entered into evidence. Hearings are concluded with no findings of fact or reasonable efforts; some observers were uncertain of the adjudication. In the worst case scenario (Bulloch County), there is no juvenile court or juvenile court judges; dependency hearings are sandwiched in between the other business of the Superior Court.

While several concerns were noted in the review of these observations, three are most prevalent and are present in multiple jurisdictions.

1) Lack of child contact

Though many attorneys (child attorneys and guardians ad litem) appeared knowledgeable about the child's case, few spent any time with the child outside of the courtroom. Coupled with the fact that children are rarely present at court makes it difficult to provide good representation or present the child's wishes during the hearing. It is generally acknowledged that the pay scale for contract attorneys does not allow for meeting with children outside the courthouse, and in some instances heavy attorney caseloads compound the problem. While raising contract rates would be helpful, CASA could be utilized more to assist attorneys with this issue.

2) <u>Lack of knowledge of the juvenile code</u>

It appears that there is room for much training on the juvenile code, juvenile court best practices, and indeed, the general rules of evidence. It is concerning that reviewers observed attorneys demonstrating knowledge of law in only one-quarter of the cases; the number of guardians ad litem addressing best interest prongs was similarly low. While judges may give attorneys limited opportunity for participation in dependency hearings (i.e., asking questions from the bench), one would expect a better showing. Training would be beneficial for both judges and attorneys.



3) <u>Inconsistent parent representation</u>

A secondary issue to the quality of child representation, and ultimately the child's permanency and well-being, is the provision of representation to parents. In several instances reviewers noted that parent asked for counsel, were refused and the hearing proceeded, ignoring their rights. Remaining in the home or reunifying with parents is always a preferred option when it is in the child's best interests to do so; this cannot always be accomplished if the parent does not receive legal counsel.

Detailed findings of overall court observations and individual cases are displayed on the tables that follow.

Table 1:

Overall Court Observations - Regularly Address:	#	Counties Addressing
Child participation	3/10 <u>30%</u>	Habersham Lowndes Marion
Diligent Search	4/8	Butts Lowndes
Ziligotti Godion	<u>50%</u>	Marion Upson
Efforts by all Parties to Achieve Permanency	4/7 <u>57%</u>	Fayette Habersham Marion Upson
Father Participation	6/8 <u>75%</u>	Butts Columbia Habersham Lowndes Marion Upson
ICWA	0/10 <u>0%</u>	Non-issue or extremely rare



Immigration	0/10 <u>0%</u>	Non-issue or extremely rare
Visitation	6/8 <u>75%</u>	Fayette Gilmer Habersham Lowndes Marion Upson

Table 2:

Overall Court Observations - Regularly Use:	#	Counties Using
3 rd Party Custody (after family & by agreement of parties)	6/9 <u>67%</u>	Butts Columbia Gilmer Habersham Marion Upson
Use of "Fill-in-the-blank" orders	4/8 <u>50%</u>	Butts Fayette Marion McDuffie
Use of CPRS	1/8 <u>12%</u>	Columbia

Table 3:

Overall Court Observations - Comments:	#
Lack legal & reasonable efforts findings	7
No CASA or CASA not used	5
Reports/documents not submitted into evidence	4
Appoint CASA as GAL	3



Out of court work is not supported (pay or caseload)	3	
No announcements of parties for the record	3	
All parties do not have legal representation	3	
Lack sworn testimony	3	
Number of comments shown, not number of courts		

Table 4:

Overall Court Observations - Training Needs Noted:	#
Advocacy	4
Basic trial skills	3
Child interview skills	2
Child welfare law	2
Number of comments shown, not number of courts	•

Table 5:

Individual Case Observation	ıs -		
Hearing Type		#	%
Judicial Review		17	33%
Adjudication		11	22
Disposition		7	14
Permanency Review		7	14
Adoption Status		5	10
Motions		3	6
Custody		1	2
TPR		1	2
Visitation		1	2
Case Plan		1	2
Hearing type not identified		2	4
Multiple responses	Total	51	100%



Table 6:

Individual Case Observations - Child Representation	#	%
Dual role	39	76%
Child Attorney Only	6	12
GAL Only	1	2
Both	5	10
Total	51	100%

Table 7:

Individual Case Observations - CASA		%	%
Participation	#	of Total	of Reponses
CASA attended hearing	5	10%	15%
CASA to be assigned	2	4	6
No CASA involvement	27	53	79
Not noted by reviewer	17	33	NA
Total	51	100%	100%

Table 8:

Individual Case Observations - Presence of Foster Parent/Placement	#	% of Total	% of Responses
Present at Court	22	43%	49%
Not present, but were notified	7	14	15
Not present, notification unknown	13	25	29
Not applicable (child living at home)	3	6	7
Not noted by reviewer	6	12	NA
Total	51	100%	100%



Table 9:

Individual Case Observations - FP/Placement given opportunity to speak during hearing	#	% of Total	% of Responses
Yes	11	50%	65%
At Court, but left early	2	9	12
No	4	18	22
Not noted by reviewer	5	23	NA
Total Present at Court	22	100%	100%

Table 10:

Individual Case Observations - Presence of Child	#	%
Present at Court	<u>11</u>	22%
In Courtroom	8	16
Outside courtroom	3	6
Not Present at Court	<u>40</u>	<u>78</u>
Presence Waived	20	39
Due to age	8	16
In school	3	6
On trip	1	2
Unspecified reason	8	16
Presence Not Waived	20	39
Total	51	100%

Table 11:

Individual Case Observations - Engagement with Child	#	%
Judge Engaged		



Yes	3	30%
No	5	50
Not noted by reviewer	2	20
Child Attorney Engaged		
Yes	3	30%
No	4	40
Not noted by reviewer	3	30
GAL Engaged		
Yes	3	30%
No	4	40
No GAL	1	10
Not noted by reviewer	2	20
Total Cases Child Present	10	100%

Table 12:

Individual Case Observations – Child Attorney demonstrated evidence of hearing preparation	#	% of Total	% of Responses
Yes	16	31%	57%
No	6	12	21
No CA	1	2	4
Unable to evaluate	5	10	18
Not noted by reviewer	23	45	NA
Total	51	100%	100%

Table 13:

Individual Case Observations – Child Attorney presented the child's		%	%
position	#	of Total	of Responses
Yes	15	29%	50%



No	10	20	33
No CA	1	2	3
Unable to evaluate	4	8	13
Not noted by reviewer	21	41	NA
Total	51	100%	100%

Table 14:

Individual Case Observations – Child Attorney hearing participation	#	% of Total	% of Responses
Positive Observations	<u>21</u>	41%	<u>54%</u>
Asked questions/cross-examination	13	25	33
Made recommendation to Court	4	8	10
Made request/motion	2	4	5
Spoke on child's behalf	2	4	5
Demonstrated knowledge of case	1	2	2
Noted substance abuse issues	1	2	2
Negative Observations	<u>21</u>	<u>41</u>	<u>54</u>
Asked no questions/no cross-examination	12	24	31
Presented no evidence	7	14	18
Discussed DV in child's presence	1	2	2
Questioned unsworn witness	1	2	2
Very limited participation	1	2	2
No participation noted	1	2	2
Unable to evaluate	3	6	8
No CA	1	2	2
Not noted by reviewer	12	24	NA
Multiple responses Total	51	100%	100%

Table 15:

Individual Case Observations – Child Attorney demonstrated knowledge of Child's health/special needs	#	% of Total	% of Responses
Yes	7	14%	37%
No	7	14	37
Child has no special needs	1	2	5



No CA	1	2	5
Unable to evaluate	3	6	16
Not noted by reviewer	32	63	NA
Total	51	100%	100%

Table 16:

Individual Case Observations – Child Attorney demonstrated knowledge of state/federal law	#	% of Total	% of Responses
Yes	7	14%	28%
No	14	27	56
No CA	1	2	4
Unable to evaluate	3	6	12
Not noted by reviewer	26	51	NA
Total	51	100%	100%

Table 17:

Individual Case Observations – Child Attorney demonstrated efforts to expedite permanency	#	% of Total	% of Responses
Yes	8	16%	38%
No	7	14	33
Not applicable/child returned home	2	4	10
No CA	1	2	5
Unable to evaluate	3	6	14
Not noted by reviewer	30	59	NA
Total	51	100%	100%

Table 18:

Individual Case Observations - Child			
Attorney demonstrated commitment		%	%
to visitation	#	of Total	of Responses



Yes	15	29%	55%
No	1	2	4
Not applicable/child returned home or TPR	7	14	26
No CA	1	2	4
Unable to evaluate	3	6	11
Not noted by reviewer	24	47	NA
Total	51	100%	100%

Table 19:

Individual Case Observations – GAL Knowledgeable on Child Safety	#	% of Total	% of Responses
Yes	10	20%	42%
No	6	12	25
No Child Safety Issues	2	4	8
No GAL	6	12	25
Not noted by reviewer	27	53	NA
Total	51	100%	100%

Table 20:

Individual Case Observations – GAL Submitted Written Report	#	% of Total	% of Responses
Yes	2	4%	6%
No	26	51	76
No GAL	6	12	18
Not noted by reviewer	17	33	NA
Total	51	100%	100%

Table 21:

Individual Case Observations – GAL Addressed Best Interest Prongs	#	% of Total	% of Responses
Yes	8	16%	27%
No	16	31	53



No GAL	6	12	20
Not noted by reviewer	21	41	NA
Total	51	100%	100%

Table 22:

Individual Case Observations – GAL Made Efforts to Expedite Permanency	#	% of Total	% of Responses
Yes	8	16%	36%
No	6	12	27
Not Applicable	2	4	9
No GAL	6	12	27
Not noted by reviewer	29	57	NA
Total	51	100%	100%

Table 23:

Individual Case Observations – Case Specific Comments	#	% of Total	% of Responses
Court Proceedings	12	24%	48%
All parties not represented/offered counsel	3	6	12
Judge asked the questions	2	4	8
No clear rulings/findings	2	4	8
Parties/representation not announced for the record	2	4	8
CASA appointed as GAL where conflict	1	2	4
Court gave detailed findings on best interest prongs in ruling	1	2	4
No notice to parents as to guardianship	1	2	4
Parties not notified of hearing	1	2	4
Temporary custodian not treated as party	1	2	4
GAL Performance	<u>_6</u>	<u>12</u>	<u>24</u>
Lack Child Contact	3	<u>6</u>	<u>12</u>
Case open a long time before met w/ child	1	2	4

Only sees children at Court	1	2	4
Well-informed, but no child contact	1	2	4
Pushing for permanency w/o allowing time to work case plan	1	2	4
Requested child be excused when he became emotional	1	2	4
Requested no visitation b/c positive screen; could have requested supervised	1	2	4
DFCS Involvement	4	<u>8</u>	<u>16</u>
No case plan	2	4	8
Allowed children to travel w/ FPs w/o notice to the Court	1	2	4
Supervisor acknowledged referral delays/ says DFCS will address	1	2	4
Attorney Participation	3	<u>6</u>	<u>12</u>
CA/GAL asked no questions	2	4	8
No closing arguments	1	2	4
Child not Present	_2	_4	<u>8</u>
Child kept out of CR because he was emotional	1	2	4
Children attend school rather than Court	1	2	4

Individual Case Observations – Case Specific Comments (Cont.)	#	% of Total	% of Responses
Lack Proper Evidence/Testimony	<u>2</u>	<u>4</u>	<u>8</u>
Documents/reports not entered into evidence	1	2	4
Lack sworn testimony	1	2	4
Only evidence presented from CM	1	2	4
Concerns about length of time in care	2	4	8
Child attorney did not have chance to see child following dismissal of abuse	1	2	4
Lack visitation resources	1	2	4
No comments made	26	51	NA
Multiple responses Total	51	100%	100%

Appendix C: Child Abuse Protocol Evaluation

Background and Purpose:

The Child Abuse Protocol (CAP) Training project works to make annual updates to the Statewide Model Protocol and to deliver training on the specifics and the implementation of the Protocol to jurisdictions across the state. With funding through the Children's Justice Act, and the Division of Human Services, the Office of the Child Advocate continued this work during 2017 with the purpose of improving and evaluating the quality and implementation of local Child Abuse Protocols across the State of Georgia. The CAP project addressed two objectives to increase compliance rates with OCGA §19-15-2, and improve safety and well-being for children across the state's 159 counties and 49 judicial circuits:

- 1. To complete 2017 Statewide Model Protocol updates on new legislation, DFCS policy and procedure, and best practices for the various disciplines involved in the investigation and prosecution of child abuse; and to provide Multidisciplinary Frontline Responder Protocol training and technical assistance to mandated local Protocol Committee members across the state to increase compliance rates with OCGA §19-15-2; and
- 2. To develop and launch a comprehensive evaluation of local child abuse protocols and training evaluations to assess compliance with OCGA §19-15-2 and improvement in the multidisciplinary response.

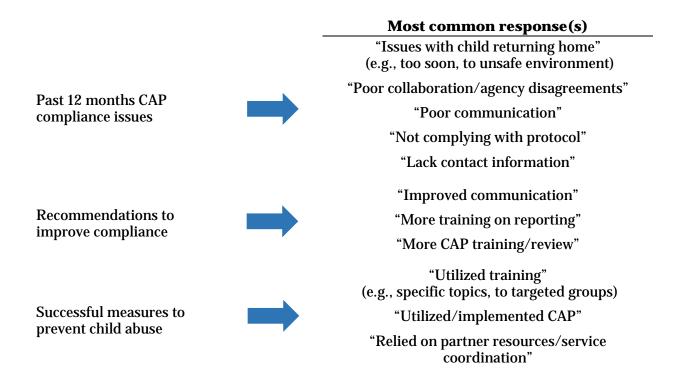
Summary – CAP Training:

OCA and its contractors delivered ten CAP trainings in 2017 covering many locations across the state, and addressing multiple child welfare disciplines. More than 400 professionals attended these trainings, including law enforcement and DFCS staff, as well as personnel from schools, Child Advocacy Centers, CASA, district attorney's offices, and health and mental health providers. Trainings were very well received and were rated very highly by trainees. Participants appreciated the material presented, particularly that about updates to the Code, but also enjoyed the convening of representatives from multiple disciplines and the opportunity to discuss local issues and hear other agencies' points of view. In addition to new information about the law, participants valued hearing about specific child abuse topics, e.g. CSEC, and receiving contact information and resources from other agencies.

Said that Training:			Most common response(s)
Was helpful in bettering relationships with MDT members	=	98%	"Communication/collaboration"
Presented something new	=	96%	"Law"
Addressed or improved multidisciplinary issues	=	87%	"Communication/collaboration" "MDT"

<u>Summary – Local CAP Development:</u>

OCA also worked with six jurisdictions, providing technical assistance on local Child Abuse Protocol development. 92 professionals participated in these work sessions and gave feedback on CAP compliance issues in their locality. While many responded that returning the child to the home too soon (e.g., before completion of investigation) was an issue in their community, problems with collaboration, communication and agency disagreements were also common. Indeed, the efficacy of the multidisciplinary team was equally, if not more important, than having established compliance with the local CAP.



<u>Summary – Local CAP Compliance:</u>

It is the responsibility of each county or circuit in Georgia to develop a local Child Abuse Protocol for the investigation and prosecution of alleged cases of child abuse (OCGA §19-15-2(b)). The written protocol shall be filed with the Division of Family and Children Services of the Department of Human Services and the Office of the Child Advocate for the Protection of Children, not later than the first day of September each year. As a part of this CAP training project, OCA conducted an evaluation of compliance with this mandate.

Nearly all counties responded to request for submission of the most recently updated protocol; 157 of 159 Georgia counties sent electronic copies of their CAP. Compared to the most recently updated Statewide Model Protocol (2016), more than three-quarters of the counties had revised their CAP within the past year. Counties with the most out-of-date protocols are shown below:

	Camden
	DeKalb
No updates in past 4 years	Fannin
(since 2012)	Gilmer
	Haralson
	Putnam
No updates in past <u>6</u> years (since 2010)	Walton
No updates in past <u>8</u> years (since 2008)	Clarke
No updates in past <u>16</u> years (since 2000)	Fayette

<u>Summary – 2017 Revised Statewide Model Protocol:</u>

Each year the Office of the Child Advocate coordinates the update of the Statewide Model Protocol to reflect Code changes as well as best practice improvements. To this end, a mini-summit of child welfare professionals convened on September 22nd. 58 professionals attended the summit and contributed to revision suggestions in groups by topic: Legislation, Child Welfare, Prevention, Child Advocacy & Sexual Assault, CSEC, Law Enforcement and Prosecution.



Post-summit protocol development began immediately following the summit. OCA contracted with Ashley Willcott, JD, CWLS, and former OCA Director, to follow up with summit participants and incorporate appropriate revisions to the model protocol. The draft of this work has been submitted to OCA and is in the proofing stage at the time of this report (December, 2017). The draft will be reissued to contributors for final edits in January 2018. When the document is finalized, the 2017 Statewide Model Child Abuse Protocol will be distributed across the state as a tool to assist each jurisdiction update their own protocols. The model protocol will also be posted on the OCA website as a reference resource.

CAP Training Evaluation Data – Table 1:

Participants by Tra	aining Location	# Signed In	# Evaluation Forms
<u>GPSTC</u>		<u>93</u>	<u>50</u>
GPSTC	12/14/16	40	-
GPSTC	04/19/17	31	28
GPSTC	09/06/17	22	22
Pataula	02/15/17	48	44
Southern	02/16/17	37	31
Oconee	02/17/17	38	32
Stone Mountain	02/21/17	89	66
Clayton	02/27/17	34	29
Fulton	03/13/17	27	16
Cherokee	06/30/17	44	41
	TOTAL	410	309

CAP Training Evaluation Data – Table 2:

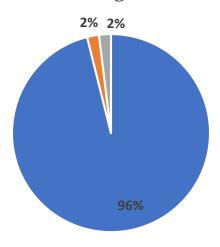
Participant Roles (# completed evaluation forms)	#	%
Law Enforcement (includes DJJ & Coroners)	103	33%



DFCS (includes SAAGs)	81	26
School	36	12
CAC/CASA	30	10
DA	19	6
Health/Mental Health Provider (includes victim services)	16	4
Court	10	3
Other Agency (Family Connection, Head Start)	6	2
No Answer	8	3
TOTAL	309	100%

CAP Training Evaluation Data – Chart 1:

Learned Something New at Training



CAP Training Evaluation Data – Table 3:

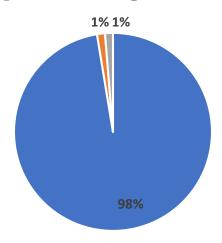
New Learning	#	%	New Learning	#	%
Specified New Learning	243	82%	Law enforcement	9	3%



			TOTAL	297	100%
Information about another agency	9	3	Did not specify new learning	54	18
Collaboration	14	5	Other agency point of view	3	1
Mandated reporting	18	6	Prosecution	4	1
DFCS	19	6	Evidence	4	1
Contact information/ resources	22	7	Expert	4	1
Interviews (i.e., forensic, how to)	24	8	Protocol (unspec.)	8	3
CAP	37	12	Child Abuse registry	8	3
Child abuse topic (i.e., CSEC, exploitation)	37	12	Reporting	9	3
Law	65	22	Multi-disciplinary team	9	3

CAP Training Evaluation Data – Chart 2:

Training Helpful in Bettering Relationships w/ MDT



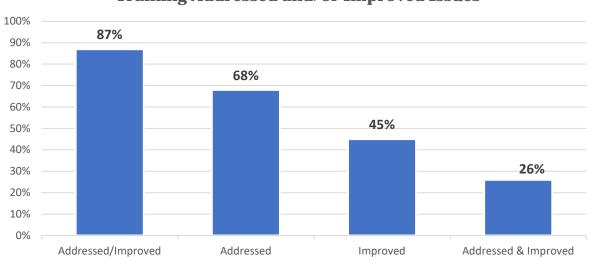


CAP Training Evaluation Data – Table 4:

Helpful	#	%	Helpful	#	%
Specified how training helpful	189	63%	CAP	8	3
Collaboration/communication	46	15	Diverse/wide agency participation	8	3
MDT	36	12	Information sharing	7	2
Networking/meeting partners	24	8	Investigations (agency roles)	4	1
Contact information/ resources	19	6	Interviews (agency roles)	4	1
Training a good forum to resolve issues	15	5	More training desired	4	1
DFCS	11	4	Information about other agencies	3	1
Information about other agencies	11	4	Law	3	1
Understanding other agency point of view	9	3	Did not specify how training helpful	112	37
			TOTAL	301	100%

CAP Training Evaluation Data – Chart 3:

Training Addressed and/or Improved Issues





CAP Training Evaluation Data – Table 5:

Addressed/Improved	#	%	Addressed/Improved	#	%
Specified how training addressed/ improved issues	122	45%	Understanding delays	5	2%
Collaboration/communication	41	15	DFCS	5	2
Multi-disciplinary team	15	6	Reporting information	5	2
Training a good forum to resolve issues	12	4	Discussed barriers	4	1
CAP	6	2	Child abuse topic (CSEC, exploitation)	3	1
Contact information/resources	5	2	Law	3	1
Interviews (forensic, how to)	5	2	Did not specify how training addressed/improved issues	148	55
			TOTAL	270	100%

CAP Training Evaluation Data – Table 6:

Information found most useful	#	%
Responded to most useful information		82%
Child abuse topic (i.e., CSEC, exploitation)	38	12
Law	36	12
Everything (not specific)	36	12
Contact information/resources	35	11
CAP	29	9
Collaboration/communication	17	6
Interviews (forensic, different types)	13	4
Other agency's protocol	13	4
Networking/meeting partners	12	4
Investigation (suggestions)	7	2



Total	309	100%
No response to most useful information	56	18
Victim trauma	3	1
Prosecution	3	1
Importance of expert witnesses/testimony	3	1
Other agencies	3	1
Understanding partner point of view	4	1
Reporting (which agencies)	4	1
Presentation	5	2
DFCS	5	2
Child Abuse Registry	5	2
Multi-disciplinary team	6	2

CAP Training Evaluation Data – Table 7:

Additional Training Topics	#	%
Responded to additional training topics	47	15%
Information about specific agencies & their roles (i.e., Childfirst, GA Cares)	8	3
More case studies/examples/activities	8	3
MDT/collaboration	5	2
Copies of the PowerPoint	4	1
Forensic interviews	4	1
Training for specific audiences (i.e., caregivers, judges, schools)	4	1
Victim assistance (i.e., follow up, resources)	4	1
Other protocols	3	1
Child Abuse topics (i.e., CSEC, DMST)	3	1



More data	2	1
Law topics	2	1
Testimony	2	1
No response to additional training topics	262	85
Total	309	100%

CAP Training Evaluation Data – Table 8:

Rate Training Experience	Strongly Agree	Agree	Total Agree	Average Rating
Instructor was very knowledgeable about the topic	80%	19%	99%	3.8
Instructor did a good job interacting with the attendees	70%	28%	98%	3.7
Instructor was able to capture my attention and keep the conversation moving	68%	30%	98%	3.6
My knowledge of other agency's role improved	51%	47%	98%	3.5
My knowledge of the Protocol improved	50%	48%	98%	3.5
My knowledge of how my work can affect the multidisciplinary investigation improved	48%	50%	98%	3.4
The multidisciplinary response will improve as a result of this training	43%	54%	97%	3.4

Local CAP Development Worksheet Data – Table 9:

Past 12 months CAP Compliance Issues	#	%
Responded to compliance issues	74	80%
Positive comments		11%
Protocol works well/no concerns/compliance as expected	10	11



Good protocol in place	1	1
Negative comments	66	72%
Issues with returning child to home	<u>16</u>	<u>17</u>
Child returned home too soon	9	<u>10</u>
- Before parent indictment	4	4
- Before disposition	3	3
- Before investigation completed	2	2
Child returned to unsafe environment	6	6
Child not returned when appropriate	1	1
Child returned to home (unspecified)	1	1
Poor collaboration/agency disagreements	8	9
Protocol issues	<u>7</u>	_8_
- Not adhering to/complying with protocol	6	6
- Need protocol update	2	2
Poor communication	6	6
Lack contact information/difficulty contacting	6	6
Child continues to have contact w/ alleged maltreator	5	5
Issues with call center	5	5
Lack of/untimely response from DFCS	5	5
Training Issues	<u>_5</u>	<u>5</u>
- need more CAP training	4	4
- unspecified training issues	1	1
Forensic Interview Issues	<u>5</u>	<u>5</u>
- DFCS FI issues	3	3
- Law Enforcement FI issues	1	1
- FIs not timely	1	1
Investigation Issues	<u>5</u>	<u>5</u>
- due to lack of communication	2	2
- due to DFCS	1	1
- due to Law Enforcement	1	1
- unspecified investigation issues	1	1
Reporting Issues	<u>4</u>	4
- Law enforcement	2	2
- School	1	1
- Cross reporting	1	1
Law enforcement Issues	3	3



Local CAP Development Worksheet Data – Table 9:

Past 12 months CAP Compliance Issues	#	%
Mandated Reporter Issues	3	3
Lack of follow-up	2	2
Case lingered on MDT schedule w/o resolution	1	1
Mental health/substance abuse issues	1	1
Sibling group separated	1	1
No response to compliance issues	18	20
Total	92	100%

Local CAP Development Worksheet Data – Table 10:

Measures recommended to improve compliance	#	%
Responded to recommended measures	82	89%
Training	<u>23</u>	<u>25</u>
More training on reporting	7	8
More CAP training/review	6	6
Mandated training	4	4
Training on signs of child abuse	2	2
Regularly scheduled training	2	2
Training on collaboration	1	1
Training on the legal code	1	1
Training on investigation	1	1
Training unspecified	5	5
Improved communication	13	14
Protocol	_9	<u>10</u>
More adherence to current protocol	5	5
Implement consequences for lack of compliance	2	1
Update protocol	1	1
Distribute protocol to all agencies	1	1
Better contact information/identify points of contact	8	9
Follow-up	_7	<u>8</u>
Need more/consistent follow-up	6	6
Need written follow-up	2	2
Collaboration	6	6
Multi-disciplinary team meeting	_6	<u>6</u>



All partners should attend/enhance partnerships	2	2
Hold regular MDT meetings	2	2
MDT unspecified	2	2
Information & data sharing	5	5
Resources to assist families & staff	5	5

Local CAP Development Worksheet Data – Table 10:

Measures recommended to improve compliance	#	%
Investigations	_4	<u>4</u>
DFCS causes issues for LE during investigations	3	3
Investigations should include more face-to-face contacts	1	1
Forensic Interviews	_4	<u>4</u>
DFCS issues with FIs	2	2
Complete within time frames	1	1
Limit number of times children interviewed	1	1
Removed barriers to reporting	3	3
Separate child from alleged maltreator until investigation complete	2	2
Need to staff individual cases	2	2
No issues to report	5	5
No response to recommended measures	10	11
Total	92	100%

Local CAP Development Worksheet Data – Table 11:

Successful measures taken to prevent child abuse	#	%
Responded to successful measures	38	41%
<u>Utilized Training</u>	_9	<u>10</u>
Provided training to all agencies/partners	3	3
Provided training to targeted groups	3	3
Provided training on specific topics	3	3
<u>Utilized CAP</u>	_7	8
Utilized/implemented protocol	4	4
Updated protocol	2	2
Increased awareness of CAP	1	1
Rely on partner resources/service coordination	6	6



Improved collaboration	5	5
Improved reporting	5	5
Improved communication across agencies	4	4
<u>Utilized MDT</u>	_4	<u>4</u>
Rely on regular MDT meetings	2	2
Rely on MDT partnerships/participation	2	2
Improved Forensic protocol	2	2
Provided more information/data sharing with partners	2	2
Assigned trained investigators	2	2
Provided up-to-date contact information	1	1
No successful measures to report	5	5
No response to successful measures	54	59
Total	92	100%

CAP Local Update Data – Table 12:

Responded to Update Request	#	%
Region 1:	11/11	100%
Region 2:	13/13	100%
Region 3:	6/ 6	100%
Region 4:	12/12	100%
Region 5:	12/12	100%
Region 6:	8/10	80%
Region 7:	14/14	100%
Region 8:	17/17	100%
Region 9:	18/18	100%
Region 10:	14/14	100%
Region 11:	18/18	100%
Region 12:	9/ 9	100%
Region 13:	3/ 3	100%



All Counties	157/159	99%
Region 14:	2/ 2	100%

CAP Local Update Data – Table 13A:

County CAP last update received Regions 1-3	Year of Last Update	# Years since Update*
Region 1:		1.4
Catoosa	2015	1
Chattooga	2015	1
Cherokee	2015	1
Dade	2015	1
Fannin	2012	4
Gilmer	2012	4
Gordon	2016	0
Murray	2017	0
Pickens	2013	3
Walker	2015	1
Whitfield	2016	0
Region 2:		0.5
Banks	2015	1
Dawson	2017	0
Forsyth	2017	0
Franklin	2016	0
Habersham	2014	2
Hall	2017	0
Hart	2016	0
Lumpkin	2017	0
Rabun	2014	2
Stephens	2014	2
Towns	2017	0
Union	2017	0
White	2017	0
Region 3:		1.3
Bartow	2017	0
Douglas	2014	2



Floyd	2016	0
Haralson	2012	4
Paulding	2017	0
Polk	2014	2
* Based on last model protocol released in fall of 2016.		

CAP Local Update Data – Table 13B:

County CAP last update received Regions 4-6	Year of Last Update	# Years since Update*
Region 4:		1.8
Butts	2014	2
Carroll	2015	1
Coweta	2014	2
Fayette	2000	16
Heard	2017	0
Henry	2016	0
Lamar	2015	1
Meriwether	2017	0
Pike	2017	0
Spalding	2017	0
Troup	2017	0
Upson	2017	0
Region 5:		2.2
Barrow	2014	2
Clarke	2008	8
Elbert	2016	0
Greene	2015	1
Jackson	2014	2
Madison	2016	0
Morgan	2015	1
Newton	2014	2
Oconee	2013	3
Oglethorpe	2016	0
Rockdale	2014	2
Walton	2010	6
Region 6:		0.5

Baldwin		2016	0
Bibb		2016	0
Crawford		NA	NA
Houston		2016	0
Jasper		NA	NA
Jones		2014	2
Monroe		2016	0
Peach		2017	0
Twiggs		2015	1
Wilkinson		2015	1
* Based on last model protocol released in fall of 2016.			

CAP Local Update Data – Table 13C:

County CAP last update received Regions 7-8	Year of Last Update	# Years since Update*
Region 7:		0.9
Burke	2015	1
Columbia	2015	1
Glascock	2015	1
Hancock	2015	1
Jefferson	2015	1
Jenkins	2016	0
Lincoln	2015	1
McDuffie	2015	1
Richmond	2015	1
Screven	2016	0
Taliaferro	2015	1
Warren	2015	1
Washington	2015	1
Wilkes	2015	1
Region 8:		0.4
Chattahoochee	2017	0
Clay	2017	0
Crisp	2015	1
Dooly	2015	1
Harris	2017	0

Macon	2016	0
Marion	2017	0
Muscogee	2017	0
Putnam	2012	4
Quitman	2017	0
Randolph	2017	0
Schley	2016	0
Stewart	2016	0
Sumter	2016	0
Talbot	2017	0
Taylor	2017	0
Webster	2016	0
* Based on last model protocol released in fall of 2016.		

CAP Local Update Data – Table 13D:

County CAP last update received Regions 9-10	Year of Last Update	# Years since Update*
Region 9:		0.9
Appling	2015	1
Bleckley	2015	1
Candler	2015	1
Dodge	2015	1
Emanuel	2015	1
Evans	2015	1
Jeff Davis	2015	1
Johnson	2015	1
Laurens	2016	0
Montgomery	2015	1
Pulaski	2015	1
Tattnall	2015	1
Telfair	2015	1
Toombs	2015	1
Treutlen	2015	1
Wayne	2015	1
Wheeler	2015	1
Wilcox	2017	0

Region 10:			0.1
Baker		2016	0
Calhoun		2016	0
Colquitt		2016	0
Decatur		2016	0
Dougherty		2015	1
Early		2017	0
Grady		2016	0
Lee		2016	0
Miller		2017	0
Mitchell		2016	0
Seminole		2017	0
Terrell		2017	0
Thomas		2017	0
Worth		2017	0
* Based on last model protocol released in fall of 2016.			

CAP Local Update Data – Table 13E:

County CAP last update received Regions 11-14	Year of Last Update	# Years since Update*
Region 11:		1.2
Atkinson	2014	2
Bacon	2014	2
Ben Hill	2016	0
Berrien	2014	2
Brantley	2014	2
Brooks	2017	0
Charlton	2014	2
Clinch	2014	2
Coffee	2014	2
Cook	2014	2
Echols	2017	0
Irwin	2017	0
Lanier	2014	2
Lowndes	2017	0
Pierce	2014	2

	2017	0
	2017	0
	2015	1
		0.6
	2016	0
	2016	0
	2012	4
	2017	0
	2016	0
	2016	0
	2016	0
	2016	0
	2015	1
		1.0
	2014	2
	2015	1
	2016	0
		2.5
	2012	4
	2015	1
* Based on last model protocol released in fall of 2016		
	* Based on last	2017 2015 2016 2016 2012 2017 2016 2016 2016 2016 2016 2016 2016 2015 2015 2014 2015 2016 2016 2015

CAP Local Update Data – Table 14:

State Summary: County CAP Last updated	#	%
Within the past year	76	48%
One year ago	47	30
Two years ago	23	15
Three-five years ago	8	5
More than five years ago	3	2
Average last CAP update	1.0 years	
Total Counties Responding	157	100%