3312 Northside Drive
Suite D-250
Macon, Georgia 31210

478-757-2661
478-757-2666 (fax)
www.oca.georgia.gov

55 Park Place, NE
Suite 410
Atlanta, Georgia 30303

404-656-4200
404-656-5200 (fax)
www.gacfr.oca.georgia.gov

Office of the Child Advocate

Melissa D. Carter, Director

OCA Interim Report: Activities from January 1, 2010 through June 30, 2010
Recommendations for Child Welfare System Progress

The Office of the Child Advocate for the Protection of Children ("OCA") was created by the General Assembly in 2000 as the state's child welfare ombudsman office, mandated 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.[i] In so doing, OCA strives to maintain child protection as a legislative and executive priority. In 2008, through an executive order and subsequent legislative enactment (Act 562), the former Office of Child Fatality Review was merged with OCA, thereby expanding the responsibilities of the agency to further include child injury and fatality review and prevention activities across the state. OCA's independent oversight and advocacy now extends to ensure the safety and protection of *all* children.

OCA's Director and staff exercise the agency's oversight authority through: 1) investigation of individual child protection and foster care cases referred to OCA by members of the public and child welfare system stakeholders and analysis of practice trends; 2) support to the state's 159 local child fatality review multidisciplinary teams in their review of unexpected or unexplained children's deaths through data collection, analysis, reporting, prevention activities and consultation; 3) education and training; and 4) legislative and policy advocacy. Though OCA performs its duties independently of any state official or state department, we strive to work collaboratively with other government agencies, non-profit organizations, and academic institutions toward greater overall system improvement.

The Office of the Child Advocate is required by law to submit periodic reports on the work of the Office with recommendations for policy and procedures to better ensure the health, safety and welfare of children.[ii] Accordingly, OCA files this Interim Report based on activities from January 1, 2010 through June 30, 2010, with recommendations for changes in policy and law for consideration in the upcoming 2010-2011 legislative session.

Operational Changes

Budget
OCA absorbed an 11% budget cut during the 2010 legislative session. More recently to comply with instructions for the amended 2011 fiscal year, OCA submitted reduction plans at the level of 4%, 6% and 8% . Those cuts were satisfied largely through adjustments within the agency's operating budget. Similarly, OCA submitted reduction plans for 6%, 8%, and 10% for the 2012 budget.

Office Consolidation
OCA continues to implement an agency-wide plan to consolidate all office operations and staff in a single location in Atlanta. Historically, OCA has been headquartered in Macon, Georgia. A second office was established in Atlanta in 2009 to accommodate the addition of a Child Fatality Review Division. Budgetary constraints as well as the administrative challenges created by managing two locations with separate and distinct functions compelled the decision to create a cohesive, wholly intact, and fully operational office in downtown Atlanta where the potential to influence policy, build critical partnerships, and marshal resources to offer effective remedies to aggrieved children and families is greatest. The consolidation and relocation of the office is expected to be complete by November 2010.

Mission & Vision
OCA is an inherently dynamic organization which must remain flexible to adapt to the changing service delivery approaches of the Division of Family and Children Services (DFCS) and other agencies and people subject to OCA's

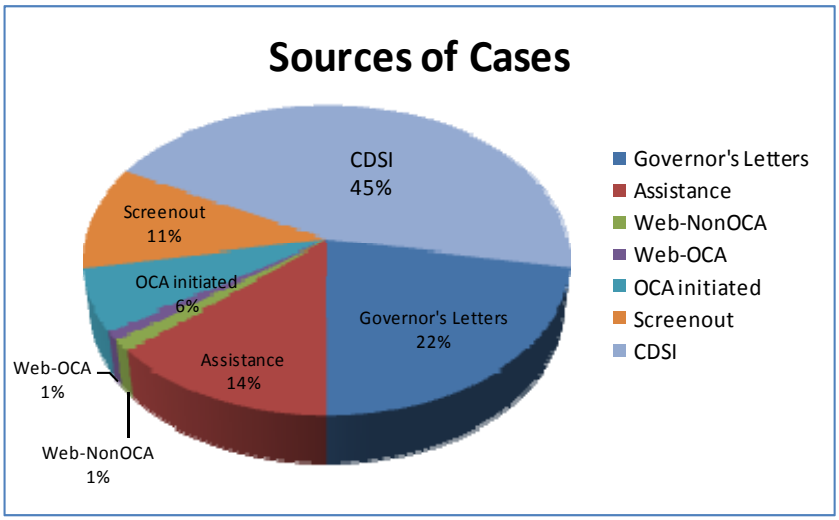
oversight authority. Thus, revisions to OCA's mission and vision statements have been undertaken by each respective OCA Director / Child Advocate to align the philosophy and activities of the office with the current child welfare policy and practice landscape and administrative leadership style. During this reporting period, OCA's mission and vision statements have again been reconsidered in light of the changing environment.

In order to properly account for the expanded scope of OCA's responsibilities subsequent to the addition of the child fatality review role and to accurately describe OCA's position as an oversight authority within the system, the following combined vision and mission statement has been considered and approved by OCA's Advisory Committee and staff:

> *Our vision is a Georgia in which all children and youth reach their fullest potential in a safe and permanent family environment. Our mission is to promote positive change in public policy and improvements in practice to ensure the safety, health, and well-being of Georgia's children.*

Child Protection & Foster Care Case Investigations

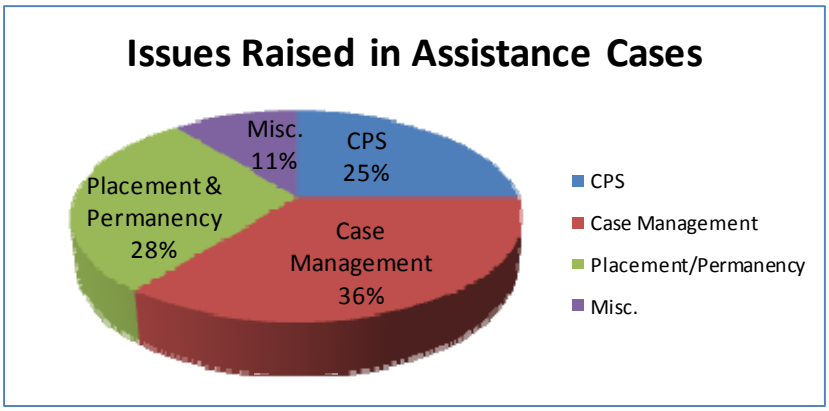
Since January 1, 2010, OCA has received 311 complaints. The referral sources of those cases are depicted below.



As a matter of internal protocol, accepted referrals are assigned generally as Assistance Cases or Investigations. Assistance cases are those that can be resolved through referrals to community resources, provision of information, and other similar time-limited responses. Investigations, by contrast, are those cases that require more intensive examination by OCA's Child Welfare Analysts. As a routine part of their investigation, analysts will contact the reporter, the DFCS or private agency caseworkers and their superiors if necessary, and other collaterals with knowledge or information about the basis of the complaint. They will also compile and review all information related to the case including the DFCS case record (typically obtained through permission to access SHINES), court documents, school and treatment records, and any other relevant information. Upon completion of their investigation, an analyst may issue a Concerns Letter outlining areas where OCA believes practices, policies, or procedures were violated or deficient and led to the problem at hand.

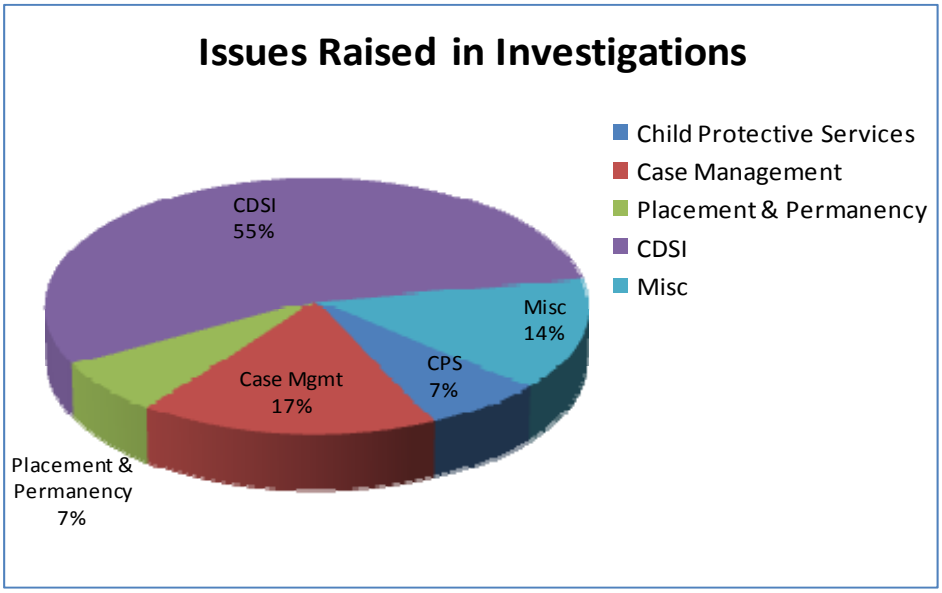
Assistance Cases

Of the 14% handled as Assistance matters, concerns regarding case management decisions represented the majority of the bases for complaints, followed by placement and permanency issues and concerns about safety decisions (i.e., "CPS" or child protective services issues).



Case Investigations

Child death and serious injury reports (CDSI) gave rise to the largest proportion of full investigations undertaken by OCA in the first half of 2010. CDSI reports are a mechanism for required internal reporting of critical incidents involving children who have an active CPS, Placement or Preventive Services case or whose family has had such a case within the past 5 years. According to DFCS Child Protection Services Policy 2108.2, the county DFCS director must submit the CDSI report electronically by the close of business on the day the county is notified of the event. Additional information obtained through the course of the ensuing investigation is also to be reported in the same way as an update to the initial report. In May 2008, OCA was added to the distribution list, providing an additional lens for oversight over cases evidencing the worst outcomes of serious injury or fatality. More than half (55%) of the investigations opened by OCA in the first six months of this year were launched based on preliminary information provided in the CDSI reports.



Concerns about case management decisions were the second most common source of investigatory concern, comprising 17% of the investigations thus far. Complaints regarding a child's permanency or placement added up to 7% of mid-year totals. This category encompasses investigations involving the quality of care and services provided by child caring institutions (CCI's). OCA analysts were involved in four such facility investigations in the first part of 2010.

Based on yearly trends, the number and nature of investigations and assistance cases seem to be consistent with previous year totals. Historical trends are depicted in charts included as Appendix A. Notably, the total number of investigations appears to be on a declining trend since 2006; however, assistance cases were not tracked as a distinct subset of investigations until 2007. That is, all accepted referrals were open for investigation from 2003 to 2006, with no distinction made in the nature of OCA's response to those complaints. Beginning in 2007, OCA began a more strategic assignment protocol and can now produce more exact reports with clearer descriptions of the agency's involvement with a particular complaint. So, the seeming reduction in the number of investigations may not be a real effect; instead, the apparent trend may reflect an artificially-inflated investigations total in early years that is now more accurately accounted for through a combined total of investigations plus assistance cases.

Child Fatality Review & Injury Prevention Activities

OCA is responsible for providing staff to and coordinating the activities of the statewide Child Fatality Review Panel (CFRP).[iii] The CFRP was created separately by statute to recommend measures to decrease the incidence of child death by collecting data; review local child fatality review reports; identify risk factors and trends; and provide training, protocols and other educational materials.[iv] The activities and recommendations of the Panel will be fully presented in the Panel's annual report, which is typically published in January, but inasmuch as OCA staff assumes the workload for the Panel's priorities and OCA management supervises those staff, major staff-led accomplishments will be briefly shared as part of this report.

- In July 2009, OCA was awarded a grant from the Centers for Disease Control based upon an application submitted by the Child Fatality Review (CFR) Division. The three-year grant supports state child fatality review strategies to enhance surveillance of the circumstances and events surrounding deaths attributed to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID). Ultimately, state activities are intended to inform the National Center for Child Death Review program and the development of a standardized,

web-based case reporting system which will, in turn, improve understanding of how and why children die and provide findings to inform prevention strategies. OCA's CFR staff were fully engaged in grant-related activities during the first half of 2010, primarily including training of coroners and local CFR teams, development of technology and distribution of equipment to local CFR committees to facilitate more timely and complete reporting of infant fatalities.

- In furtherance of the CFRP's focus on drowning as a mechanism of child injury and death, OCA staff has forged a partnership with Safe Kids Georgia for the development of a statewide prevention program. Additionally, OCA staff has involved key academic partners through engagement with faculty from Emory and Georgia State University who will assist with data linkage, analysis and mapping that will inform the primary, secondary, and tertiary prevention strategies for drowning deaths of each age group.

- OCA, through its Child Fatality Review Division, is sharing child death case report data with the National Transportation Safety Board (NTSB) in cooperation with the NTSB's efforts to better understand possible reasons why children, ages 0-12, are not restrained, particularly in infant and child car seats and seat belts, in motor vehicles when circumstances suggest that they should have been.

- OCA is partnering with the Division of Public Health, Maternal and Child Health (MCH) Division, to enhance the state's activities under the federal Title V block grant. Specifically, MCH has agreed to provide support for data analysis, reporting and statewide training in exchange for reciprocal information-sharing on child death and injury prevention issues that will continue to support the state's application and receipt of the federal monies.

Education & Training

- One *Finding Words* basic course was held during the period of this report, with funding support from the federal Children's Justice Act (CJA) grant administered by DFCS. Thirty-four participants, representing DFCS, law enforcement and prosecutors, were trained in the best practices of forensic interviewing techniques in May, and OCA is offering two additional *Finding Words* trainings, one each in August and September.

- The Youth *Law Conferen*ce, sponsored by OCA with the use of Children's Justice Act federal funds administered by DFCS, will be held October 27-29, 2010. This conference is an annual training offered by OCA through partnerships with the Georgia Association of Counsel for Children, the Supreme Court of Georgia Committee on Justice for Children, and other organizations *as an opportun*ity for attorneys or volunteer advocates representing children in juvenile court deprivation matters to receive their pre-service training in accordance with the requirements of O.C.G.A. § 15-11-9(b). Despite that primary goal, session topics and speakers are scheduled to attract attorneys representing *any party in a deprivation or delinquency case.*

- Once CJA grant funds were released in late June, OCA staff began planning for the second year of the Training Academy. The Training Academy is comprised of subject matter experts from the fields of medicine, forensics, law enforcement, prosecution and child protective services. A 3-day basic child abuse course covering the investigation and prosecution of neglect, sexual, physical and fatal abuse in children is offered to local multi-disciplinary teams. Numerous one-day courses covering topics such as: Special Needs Victims and Witnesses (focused primarily on Autism); Crime Scene Investigation; Combating Defenses in Shaken Baby Cases; Sexual Abuse 101; Child Abuse 101; Abusive Head Trauma; Utilizing Expert Witnesses; and, Witness Skills are also offered.

- OCA's Director continued to participate in local Justice for Children summits, presented in partnership with DFCS and the Supreme Court of Georgia Committee on Justice for Children. Since the beginning of 2010, summits have been held in seven judicial circuits, covering 25 total counties. These summits provide opportunities for local juvenile court stakeholders to convene to examine their child welfare practices around achieving permanency and engaging youth in permanency planning. Data specific to the local jurisdiction's performance on the federal Child and Family Services Review (CFSR) outcomes is also presented and used as a framework for action planning specific to that locale.

Policy & Legislative Advocacy on the Horizon

- In an effort to address areas of concern regarding DFCS safety practices, OCA will sponsor a Safety Summit on October 22, 2010. DFCS administrators have agreed to participate with all interested juvenile court judges in an open forum to comprehensively examine this state's diversion/family support policies and practices. The goal of this meeting is to devise common strategies for refining strategies to safely reduce the number of children in foster care in ways that ensure the safety of children who are the subject of abuse and neglect reports. A related goal is to strengthen trust among stakeholders in local jurisdictions and at the state level by identifying alignments in values and practices and targeting the gaps that exist between DFCS' diversion practice and the more classic model of differential response.

- OCA continues to engage with DFCS leadership in efforts to refine the agency's safety resource policy, which in turn will promote better practice in the field. OCA released a report with findings from its independent investigation of a sample of cases and recommendations for policy changes in July 2009. An update to that report will be released under separate cover in September 2010.

- Based on national studies and Georgia cases indentified through the Committee on Justice for Children's Cold Case Project, OCA and DHS-DFCS leadership began crafting a process for improved oversight of the administration of psychotropic medications to children in foster care. The initial proposal envisioned a panel of child psychiatrists who would independently review treatment recommendations and provide expert consultation to DFCS case managers so that agency consent to medications was truly informed. Though the initial proposal did not earn the necessary support of the Department of Behavioral Health and Developmental Disabilities, multi-agency efforts to improve upon health outcomes for children in foster care continue to be pursued energetically.

- After several cases involving challenges with transitioning developmentally disabled youth from foster care to adulthood at age 18 were referred by DFCS administrators to OCA, OCA convened a work group consisting of representatives from DFCS, DCH, DBHDD and the Developmental Disabilities Council to tackle systemic solutions to the barriers of accessing community-based Medicaid waivers for care. Since August, three preliminary meetings have been held to frame the issues. Future meetings will involve community service providers and advocates, whose insights and involvement are critical to successful pursuit of those strategies to better serve children and families that rest within budgetary realignment and cross-agency coordination.

Recommendations

In light of OCA's past work and more recent activities during the first half of 2010, the following recommendations are offered for consideration by legislators, policymakers, agency administrators, and child welfare system stakeholders:

1. Refining Diversion/Family Support Practices to include development of those components of a "model" differential response system that are missing from Georgia's safety practice and issuance of a statewide policy or law to inform and guide critical practice decisions in the field.

Since 2008, DFCS has cooperated in the sharing of safety data with OCA, and OCA affirms those data reflect sound practice trends. However, community stakeholders and external partners, whose support for the child welfare system is vital, do not have confidence in this practice. Stakeholder input was not sought in the initial development of diversion (also commonly referred to in other states as "differential response") practice as a way to safely reduce the number of children in foster care and respond to allegations in ways more consistent with family-centered practice (i.e., limiting unnecessary and unwarranted government intrusion in families and the trauma to children that accompanies such disruption). In addition, local DFCS offices have been encouraged to develop their own standards for diversion, resulting in local protocols that vary in notable ways in their framing of what constitutes low to moderate-risk cases eligible for a diversion response.

In the recent past, OCA has recommended the increased use of both qualitative and quantitative performance measures that promote consistency of practice at acceptable standards. DFCS closely monitors performance in this arena largely through the use of quantitative measures, and specifically relies heavily upon the rate of recurrence of maltreatment. OCA continues to assert its recommendation that the recurrence measure be supplemented by other routinely-tracked information including the amounts and types of services provided, the satisfaction level of professionals and consumers

with DFCS' work, or the number of family assessments completed within a given time frame. To the extent DFCS administrators might already be accumulating this information internally, OCA strongly recommends public reports and engagement with external stakeholders.

In addition, OCA recommends a comparative analysis of DFCS' diversion/family support practice with the "model" differential response systems from other states. That assessment will show that a critical missing component is the requirement for an assessment to be conducted in all cases, regardless of whether the case is ultimately disposed of through diversion or the more formal investigation process. Arguably, anything short of that requirement renders the child protection agency unable to make a proper and informed determination as to any safety risk to the child. To the agency's credit, DFCS contracted with JoAnn Lamm, the architect of North Carolina's differential response system, to conduct such an evaluation and follow-up on the preliminary examination conducted by the Carl Vinson Institute of Government at the University of Georgia. Unfortunately, the agency has to date declined to release publicly her report of findings and recommendations despite increasing demand for it. The state DFCS office, instead, plans to release the report first to a select group of internal staff and external partners convened as a steering committee to guide the development of the agency's Safety Practice Package. The members of that group have been selected and an initial formation meeting has recently been held.

To further DFCS' efforts to confront the concerns about its safety practices, OCA is hosting a ***Safety Summit*** with juvenile court judges and DFCS administrators to discuss these issues in an open forum. However, as a consequence of the historical lack of transparency around diversion and the failure to engage with stakeholders in a sustained and meaningful way, stakeholders and the public do not have confidence in the ability of the state's child welfare agency to effectively execute its child protection mandates. Thus, OCA makes the following recommendations:

- DFCS should be strongly encouraged to release immediately the report authored by JoAnn Lamm and take action to improve diversion/family support policy and practice;

- Safety measures used by DFCS to monitor performance should be more robust and stakeholders should be given an opportunity to help design those measures;

- Legislators and policymakers should consider a statutory amendment to require assessments in all cases in which DFCS provides services prior to the determination of how a case will be managed.

2. Adoption of a clear and strategic focus on well-being outcomes for children in foster care, specifically including a process for review of the administration of psychotropic medications.

In the summer of 2010, DFCS was released from its federally-mandated Program Improvement Plan that resulted from the state's inadequate performance on the Child and Family Services Review (CFSR). Because of the penalties that attach to failure, the CFSR and the state's PIP have consumed a significant amount of the agency's focus and resources. Though the CFSR assesses the state's performance on each of the three primary child welfare outcomes of safety, permanency, and well-being the safety and permanency measures predominate in number and therefore demand the most focus. Now that the state has successfully achieved and maintained measures related to safety and permanency outcomes, DFCS and its community partners are freed to focus equally on children's well-being. Well-being broadly consists of children's health (physical, mental/behavioral, and dental), education, and connections to the community and family.

The recent passage of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 and the state implementation legislation to ensure compliance also direct a new energy to well-being outcomes. OCA recommends that DFCS and the state at large continue to invest time and effort to understand the goals and requirements of the state and federal law and work collaboratively to implement it successfully. Much cross-system work must be invested toward successful implementation of the educational stability and health coordination outcomes in particular.

One area of well-being in need of immediate attention is the phenomenon of poly-pharmacy, particularly with respect to the administration of psychotropic medications to children and youth in foster care. Findings related to the misuse and overuse of psychotropic medications to children in foster care are well-researched and thoroughly documented at a national level, and state data suggest that such concerns are well-founded in Georgia. Based on research data, children in

foster care are at extremely high risk for emotional and behavioral disturbances. Children in state custody disproportionately utilize state-funded mental health services, and are prescribed psychotropic medications at a higher rate than other children. In 2009, more than 50% of teenage children in state custody in Georgia were prescribed at least one psychotropic medication, and nearly one in three teenagers were prescribed at least one antipsychotic medication; nearly 5% of these teenagers were prescribed at least four different psychotropic medications.[v] Younger children in state custody were prescribed psychotropic medication only slightly less frequently.[vi]

Utilization and claims data are persuasive, but actual cases of children in foster care provided are even more compelling. The Supreme Court of Georgia Committee on Justice for Children recently released the final report of its "Cold Case Project," which identifies youth who are languishing in foster care for extended periods of time and provides advocacy to remove legal barriers to permanency. Bases on analyses of 214 "cold cases," that Project included the following findings and recommendations:

> One out of three cold case children resided in an institution or residential therapeutic treatment setting for mental health problems. A review of psychological assessments completed by mental health professionals indicates the most common diagnoses included Attention Deficit/ Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder (PTSD), Oppositional Defiant Disorder (ODD), and various cognitive issues. Half of cold case children were diagnosed with ADHD; one in four was diagnosed with PTSD. Two thirds of children were prescribed medication at some point and those on medication average two drugs per child.
>
> Given the high rate of mental health issues and their influence on permanency options, all children receiving institutional care for mental health issues should be regularly reviewed by an independent psychiatric entity to ensure proper care. Immediate action should be taken when a child's treatment is called into question. To promote quality care, advocates with mental health training should be encouraged to regularly visit institutionalized children and voice their needs.[vii]

In furtherance of a joint agency strategy and at the request of the Department of Human Services Division of Family and Children Services (DHS-DFCS), OCA proposed the establishment of a medication review program to improve the safety and effectiveness of psychopharmacotherapy for the treatment of emotional and behavioral health disorders in children who are in foster care. The program as initially designed would provide independent clinical review of the administration of psychotropic medications to children in state custody, expert consultation to case managers and foster care providers, education, and policy development. Unfortunately, despite significant investment of planning resources, the OCA program model does not have the necessary support from all involved agencies. As a less expensive alternative, DBHDD administrators proposed making use of the Quality Improvement Organizations (QIOs) contracted by the Centers for Medicare and Medicaid Services (CMS). QIOs are private, mostly not-for-profit organizations, which are staffed by health care professionals trained to review medical care, help beneficiaries with complaints about the quality of care, and implement improvements in the quality of care.[viii]

The decision as to what model is preferable is a complex one, especially in challenging economic times. At this time, OCA reserves an opinion on the program design and simply asserts the recommendation that a process be developed through which qualified clinicians provide *independent* review of treatment recommendations for children in foster care. Importantly, the process must provide an avenue through which advocacy can be provided for individual children as well as for systemic improvement to ensure the best health outcomes for all children in foster care.

3. Broaden the juvenile court permanent guardianship statute to allow for the juvenile court to be accessed by children and families without the prerequisite of a deprivation petition.

OCA was the lead agency proponent for a 2008 legislative change to the Juvenile Code to create a permanent guardianship permanency option. As it is currently worded, O.C.G.A. §15-11-30.1 provides for juvenile court jurisdiction to appoint a permanent guardian for a child ... before the court *"as a result of an adjudication that the child is deprived ...."* OCA recommends consideration of a legislative amendment to broaden access to this disposition by eliminating the prerequisite finding of deprivation. Pursuit of this recommendation would modernize state law in harmony with the

family-centered practice orientation of our child welfare system and provide a more appropriate forum for transferring custodial authority of a child in a family with which DFCS is involved.

OCA published a report in July 2009 documenting concerns with the use of safety resource placements, generalized as follows.

> First, the agency appears to be using safety plans and temporary guardianships to avoid the involvement of the juvenile court in the child protection process, thereby depriving the child and family of the many legal and practical benefits the court offers and circumventing purposeful federal and state child protection schemes. Second, the agency's reliance on safety plans and probate court temporary guardianships can deprive the child of stability and permanency and may further delay resolution of the family's issues. Third, misuse of safety plans and temporary guardianships can leave the child drifting from home to home, exposed to risk, and separated from siblings, friends, and family for long periods of time. Finally, OCA questions whether the use of safety resources for long periods of time decreases the agency's incentive to provide the services necessary to fix the parental issues and reunite the family quickly.

The defense of these practices rests within the core principles of family-centered practice, which aims to empower families to make decisions and limit unwarranted government intrusion. Criticisms center on the theme that the families subject to these practices, by virtue of the fact they have come to the attention of DFCS, deserve greater scrutiny of their parenting decisions, including conditional safety arrangements. Moreover, the guardianship available through Probate Court is inherently temporary as it may be dissolved by the mutual consent of the guardian and the parent. Such dissolution does not trigger notice to DFCS or the juvenile court which may mean that a child can be returned to an unsafe situation.

Broadening the juvenile court permanent guardianship statute is one way to resolve the procedural and safety concerns raised when families whose conduct may not support a formal finding of deprivation need to reconfigure their family for the sake of a child. Knowledgeable of available resources and experienced with complex family dynamics, the juvenile court is arguably in a better position to evaluate the parents' decision, the care-giving competencies of the nominated guardian, and the actions of DFCS in arriving at this legal option. Additionally, the juvenile court guardianship statute is designed to be permanent; i.e., endure until the child reaches the age of majority and established pursuant to a high legal standard for modification or revocation. Finally, allowing for this option in juvenile court would also address the concerns of Probate Court judges who have expressed growing discomfort with presiding over a transfer of custodial rights facilitated by DFCS outside of juvenile court jurisdiction. There should be no reason why the juvenile court and its specifically-purposed jurisdiction should be avoided in order to give effect to parental decision-making and self-determination over a child's living situation and care-taking.

---

[i] *See generally* O.C.G.A. §§ 15-11-170 *et seq.*
[ii] O.C.G.A. § 15-11-173(4) (2010).
[iii] *See* O.C.G.A. § 19-15-4 (2010).
[iv] *Id.*
[v] Unpublished Medicaid claims / utilization data, categorized by age of child served during calendar year 2009, provided to Dr. Brent Wilson.
[vi] *Id.*
[vii] Supreme Court of Georgia "Cold Case Project," full report available at http://w2.georgiacourts.org/cj4c/.
[vii] http://www1.cms.gov/QualityImprovementOrgs/