Child Protective Systems Oversight Committee

Annual Report 2016

An annual report to the Sacramento County Board of Supervisors from the Sacramento County Children's Coalition, Child Protective Systems Oversight Committee.

Acknowledgements

The Sacramento County Child Protective Systems Oversight Committee[1] (Oversight Committee) of the Sacramento County Children's Coalition studies and monitors the state of the child protective systems in Sacramento County at the behest of the County Board of Supervisors addressing issues identified in reviews of critical incidents (death and near death occurrences) and/or a review of organizational issues and practices within the general child protective system.

All of the information outlined in this report is general and does not purport to be related to any particular case, person, or occurrence. A Sacramento County Superior Court order prohibits members of the Oversight Committee from disclosing specific confidential case information.

The Oversight Committee wishes to thank the Sacramento County Department of Health and Human Services (DHHS) and Child Protective Services (CPS) staff, especially Dr. Sherri Heller and Michelle Callejas for being responsive to the inquiries made by the Oversight Committee, and their willingness to make continual improvements. Thank you to Abigail Nosce for the technical assistance she provided in putting this report together and her support to the Oversight Committee. The collaborative culture between DHHS, CPS and the Oversight Committee is essential for the improvement of the safety of children and families in our community.

[1] See Appendix A for members of the Oversight Committee.

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History and Role of the Child Protective Systems Oversight Committee

The Sacramento County Children's Coalition was established by the Board of Supervisors (BOS) in 1994. It is charged with assessing community needs, and evaluating existing services relating to the health and wellbeing of children. By resolution of the BOS, the Children's Coalition is responsible for, among other things, providing community oversight of the County's child protective systems through the Coalition's Child Protective Systems Oversight Committee.

In January 1996, the County Executive appointed the Critical Case Investigation Committee (CCIC) and charged it with examining and evaluating the child protection system in the context of its nexus to the homicide of Adrian Conway. Its primary purpose was to examine the Conway case to evaluate the efforts of all service providers, including DHHS, Family Preservation and Child Protection Division.

In May of 1996, the CCIC issued its final report. It recommended establishment of, within an existing community advisory group, the function of "community oversight of child protective services, including preparation of an annual report to the BOS on outcomes and effectiveness of the system along with recommendation for policy and program changes." It identified a nonexclusive list of areas which the annual report should address:

- Findings from the Child Death Review committee and assessment of impacts on the child protection system;
- Overall statistics and program analysis;
- A quality assurance review of at least one operational unit in the child welfare system;
- Comparison of outcomes for children with other communities in the state and nation;
- Identification of exemplary programs and practices with recommended application to the County;
- Report on community satisfaction with the child protections system; and
- Review and report on progress on recommendations contained in the CCIC's report.

In July 1996, the BOS approved DHHS' recommendation that the BOS establish the Children's Coalition as the oversight body called for by the CCIC, now called the Child Protective Systems Oversight Committee (Oversight Committee).

The Bylaws of the Children's Coalition define the duties of the Oversight Committee. The Oversight Committee is responsible for performing community review of critical child protective services cases, culminating in an annual report, which includes outcomes and effectiveness of the system with recommendations for policy or program changes. The report may include review of progress on the recommendations contained in the CCIC report and other items identified in the 1996 CCIC report. It must be approved by the Children's Coalition which presents the report to the BOS.

The Oversight Committee is not limited to oversight of the DHHS CPS Division. It can, in its discretion, expand its inquiry to the County's child protective services system generally, including service providers

under contract with the County. Such an examination would necessarily be more systemic in character as access to an individual's records would be limited based upon a spectrum of confidentiality laws. The Juvenile Court order allows access only to those records that fall within the purview of Welfare and Institutions Code section 827, i.e., records related to dependency proceedings. Ultimately, the decision as to the focus and extent of its oversight functions rests within the exclusive determination of the Oversight Committee, subject to any limitations in the Children's Coalition Bylaws or BOS action.

Annual Report 2016

I. Introduction

The Child Protective "Systems" Oversight Committee focuses on agencies within our community that play a role in ensuring the safety of children. This year's report addresses collaboration between multiple agencies within Sacramento County.

Following the Oversight Committee's 2014 and 2015 Annual Reports, resources were allocated by the Board of Supervisors (BOS) to address identified needs. These resources were used to begin the Quality Improvement Committee to enable updates to existing Policies and Procedures (P&Ps), the authoring of new ones, and to facilitate the placement of policies and procedures in a mobile format to make them easily accessible for Social Workers (SW). The Division of Public Health also gained additional Public Health Nurses (PHNs), and CPS gained additional SW positions and IT support for online training. The Oversight Committee has observed progress in these areas and wishes to thank the BOS for their support.

For this Report, the Oversight Committee, along with its Child Protective Systems Subcommittee, focused on identifying other community agencies charged with ensuring child safety or providing resources or services that contribute to improving the health and wellbeing of the children and families in the community. The Oversight Committee invited these identified agencies to present information about them and their collaboration with other agencies. The following agencies gave presentations:

1. Sacramento County Sheriff's Department
2. Sacramento City Police Department
3. Sacramento County Department of Human Assistance (CalWORKS program)
4. Sacramento County Department of Health and Human Services (CPS and Public Health Divisions)
5. Sacramento County Child Death Review Team

The specific focus on critical incidents is limited this year because this report covers a shorter timeframe than past reports and this year's focus is primarily on collaboration. The CI subcommittee meets monthly to examine critical incidents, death and near death situations. These reviews include Quality Assurance Reports and Memos prepared by DHHS in response to the death/near death of a child due to maltreatment. Each case is reviewed and discussed to determine whether or not CPS's responses prior to the death or critical incident were adequate. In 2016, the cases that were reviewed showed similar issues noted in previous reports that are still present, including critical thinking errors. Recommendations to address these issues are included herein.

II. 2016 Presentations to the Oversight Committee

The Oversight Committee received numerous updates and presentations over the course of this reporting period. The information received provided updates on the recommendations from the 2014 and 2015 Annual Reports and there were also several presentations from community organizations addressing collaboration.

June 2016

California's Child Welfare Continuum of Care Reform (CCR)

Associate Executive Director Doug Johnson of California Alliance of Child and Family Services and Executive Director David Ballard of Children's Receiving Home provided an introduction to California's Child Welfare Continuum of Care Reform.

- Senate Bill (SB) 1013 (approved in June, 2012) required that the California Department of Social Services (CDSS) consult with a number of stakeholder organizations to develop recommendations for revisions to the State's current system serving youth in foster care.
- CDSS produced a report in January 2015 outlining a series of recommendations. These recommendations would shift the purpose of group homes away from providing long-term placement for foster youth, to providing short-term residential treatment as an intervention. It would also provide targeted training and support to families who provide foster care so they are better prepared to care for youth living with them.
- Issues of concern around implementation of CCR were discussed. Questions were addressed.

Recommendations

- Track and follow.

September 2016

Sacramento County Public Health Nurses (PHNs): Review of Services and Recommendations

Sacramento County Public Health Officer Dr. Olivia Kasirye, CPS Acting Health Program Manager Angie Butters, CPS Program Planner Cynthia Vanzant and CPS Public Health Nurse Supervisor Blanca Gomez educated the committee about the CPS PHN continuum of services. Over time, Public Health has become aware of the need to be more involved with CPS. Many health issues can be tracked back to adverse childhood experiences.

Over the years, the Critical Incidents subcommittee has reviewed cases where referrals with allegations of medical neglect were not adequately assessed. It is recognized that SWs do not possess the training needed to assess the risk factors that medical conditions present. Having PHN resources available to SWs staffing the Emergency Hotline room, and providing training around how to best utilize these resources, would be beneficial.

Recommendations

- Provide the Emergency Hotline with PHN resources which could assist with determining response times and conclusions on referrals with allegations of medical neglect, and staff training around how to best utilize these resources.
- PHN assigned to every case that meets criteria, utilizing on-call, contract or registry nurses to fill the gaps as needed.
- Develop the resources to allow PHNs to follow high-risk medical children after the cases are closed with CPS. Currently, PHN services to child/family cease once the CPS case closes.

October 2016

Child Death Review Team (CDRT) 2013-2014 Report

Child Abuse Prevention Center Chief Program Officer Stephanie Biegler and CDRT Chair Marian Kubiak provided an overview of the Sacramento County CDRT 2013-2014 Report presented at the October 4, 2016 Board of Supervisors (BOS) meeting.

- The mission of the CDRT is to: Review all child fatalities of Sacramento County children age 0-17; Enhance the investigation of all child deaths through multi-agency review; Develop an aggregate description of all child deaths to identify cause of death, including abuse/neglect; and, Develop recommendations for the prevention and response to child deaths based on the reviews and aggregate information.
- In 2013-2014, 261 children age 0-17 residing in Sacramento County died (average death rate of 36.4 per 100,000). This is a decrease from 409 children stated in the 2010-2012 CDRT Report (average death rate of 38.1 per 100,000). The total County and non-County resident child decedents in Sacramento was 265.
- Tracked risk factors included: family history of alcohol and/or other drug abuse, family history of violent and/or non-violent crime, decedent enrolled in government aid programs, decedent or family history involvement with Sacramento County CPS, family history of domestic violence, and family history of mental health issues.
- Child maltreatment was involved in the deaths of 28 children – 16 of which were Child Abuse and Neglect (CAN) homicide.
- 76% of CAN homicide perpetrators were the parent
- Risk factors were known to be present in 94% (15 of 16) of CAN homicides

Recommendations

- Track and follow.

November and December 2016

Collaboration with Local Law Enforcement

Sergeant Patrick Kohles of Sacramento Police Department's Office of Investigations provided an overview of how the Department's Child Abuse/Sexual Assault Unit responds to and investigates child abuse and sexual assault.

- The Child Abuse/Sexual Assault Unit not only investigates incidents of child abuse (for children under the age of 14) and sexual assault (all ages), but it also provides outreach and education to the community, reinforcing good safety precautions as well as the importance of having a plan and being aware.
- The Sacramento PD describes multiple examples of community collaboration in the area of child protection. Currently CPS SWs are co-located with officers to provide consultation and act as a liaison to officers and SWs. CPS is in the process of putting field SWs in law enforcement offices to respond to abuse and neglect reports. The Sacramento PD collaborates with CPS, hospitals, physicians, and schools to name a few. Sometimes response times can be long as officers may be responding to other calls which are triaged.

Sergeant Tony Saika of Sacramento County Sheriff's Department's Centralized Investigations Division provided an overview of how the Department's Child Abuse Bureau responds to and investigates child abuse.

- The Child Abuse Bureau investigates crimes against children under the age of 18, and sex abuse crimes of children under the age of 14 (14+ are investigated by the Adult Sexual Assault Unit). A child abuse case may involve infant death, physical abuse, child molest, neglect and indecent exposure.
- New reports are prioritized based on level of severity and take no longer than five days to process once they are submitted to the Child Abuse Bureau. From January 1, 2016 to the date of this presentation, 816 reports were taken and 250 were assigned to a detective to investigate.
- The Child Abuse Bureau takes a multi-disciplinary approach, working with many other child protective agencies. Detectives have close working relationships with the District Attorney's Office, Child Protective Services, other law enforcement agencies, physicians, and other emergency personnel. A CPS liaison is outstationed in the Child Abuse Bureau's office. This helps by expediting processes, educating staff about policies and procedures, and ensures effective and efficient collaboration. There will be a staff person from WEAVE (Women Escaping A Violent Environment) outstationed in the unit's office soon.
- The Child Abuse Bureau used to have ten detectives on staff, but was reduced to seven during the County's budget cuts in 2009. No new positions have been restored since then. An additional detective would help alleviate some of the workload.

Recommendations

- Fully staff the Child Abuse Bureaus of local law enforcement agencies.

January 2017

Department of Human Assistance (DHA) CalWORKs Program: Collaboration with CPS

Deputy Director Gladys Deloney provided a comprehensive overview of multiple DHA initiatives and programs that involve active collaboration with CPS and the community.

- DHA has a lead role with CPS in creating Multidisciplinary Teams (MDTs) to serve identified neighborhoods with the highest number of African American Child deaths. This includes staffing the MDTs with CalWORKs Human Services Specialists, co-located with CPS SWs.
- DHA and CPS collaborate on ensuring the health and safety of pregnant and parenting teens who apply for public assistance.
- DHA and CPS work together to ensure children placed in out of home care receive financial support and medical coverage to promote family stability.

Concern

- Due to the low number of referrals to CPS from DHA, there appears to be under-reporting of suspected child abuse.

Recommendations

- Additional mandated reporter training for DHA staff.

Sacramento County Department of Health and Human Services CPS updates

Deputy Director Michelle Callejas provided updates on the work of CPS with regard to the 2014 and 2015 Annual Report Recommendations. The specifics are provided in the next section.

III. Follow-up on 2015 and 2014 Recommendations

The information for this section was obtained from CPS Deputy Director Michelle Callejas and other members of the CPS organization.

2015 Annual Report Recommendations

2015 Recommendation 1 (from CI Subcommittee): Board of Supervisors develop a countywide commitment to encourage other departments – such as Law Enforcement, Mental Health, hospitals, and the courts – to become more aware and responsive to how their decisions impact the safety of children and the work of CPS, and collaborate better with CPS and each other.

Findings:

CPS reports they continue to forge partnerships and work collaboratively with both system and community based partners that serve children and families. In 2016, new partnerships were developed through projects with other child serving agencies including:

- Developing seven Community Incubator Leads (CILs) as part of the Steering Committee on Reduction of African American Child Deaths that will offer resources to families in neighborhoods that have the highest number of African American child deaths. This is a collaborative partnership with multiple county agencies and includes staff being co-located at the following agencies:
  - Greater Sacramento Urban League (Oak Park)
  - Liberty Towers – Community Impact Center (North Highlands/Foothill Farms)
  - Building Healthy Communities (Fruitridge/Stockton)
  - Mutual Assistance Network (Arden/Arcade)
  - South Sacramento Christian Center (Valley Hi)
  - Roberts Family Development Center (Del Paso)
  - Focus on Family (Meadowview)
- Identifying homeless programs in conjunction with Department of Human Assistance (DHA), Sacramento Housing Redevelopment Agency (SHRA), Sacramento Steps Forward (SSF) and Volunteers of America (VOA) that would best align with supporting families who are at risk of being homeless via Paid Re-Housing Prevention resources.
- Reinitiating quarterly meetings at the Mexican Consulate to help with collaborative and supportive efforts for families within the community.
- Partnering with Probation, including quarterly meetings with management, to collaborate, problem-solve and continue to build relationships in order to improve safety for youth, including Commercially Sexually Exploited Children (CSEC) and Crossover Youth, and ensure accountability on all levels.
- Holding community partner meetings which include the Division of Behavioral Health Services (BHS), Children's Law Center, Probation, Sacramento Sheriff's Department, Sacramento Police Department, Children's Receiving Home and other service providers to share data, improve communication and increase system-wide responses to high needs youth.

- In these meetings, they strategize and develop cross-system processes for improving collaborative responses regarding child safety (installation of a POD camera across from the Children's Receiving Home is currently in process).

- Collaborating with BHS regarding the Community Support Team, and ensuring youth with significant trauma and behavioral needs are supported and linked to services as soon as possible.
- In 2017 CPS reports they will partner with UCD CAARE Center on their PC-CARE program which will support children ages 0-5 in foster care by providing in-home UCD services to the child and caretaker to help with the transition to a new home through coaching and psycho-education with the ultimate goal of achieving placement stability.
- Also in 2017 CPS reports they will begin holding law enforcement meetings again on a quarterly basis and will include CPS Emergency Response (ER) unit managers, Elk Grove Police Department, Sacramento Sheriff's Department, Sacramento Police Department, Citrus Heights Police Department, Folsom Police Department and Galt Police Department to discuss collaboration toward increased teaming, any jurisdictional issues, and to share updates pertinent to each agency's role in regard to child and family safety.
- CPS reports they are currently working on expanding out station opportunities with Sacramento Sheriff's Department, Sacramento Police Department and school districts.

Plan:

The Oversight Committee will continue to review collaborative efforts and advocate for a framework in which community partners are informed about critical incidents where collaboration was missing or inadequate. The Committee will also continue to push for a Blue Ribbon Panel made up of members from Law Enforcement, Human Services agencies, District Attorney's Office, Probation, hospital systems, health plans, California Children's Service (CCS), Alta Regional Center, and community-based organizations to address better collaboration, identify gaps and offer solutions. This panel would mirror a similar panel approved by the BOS addressing the disproportional rate of deaths among African American children.

2015 Recommendation 2 (from CI Subcommittee): Board of Supervisors support and encourage CPS management's efforts to improve employee retention, particularly around the issues of high caseloads and employee morale. What this support means is that there need to be more Social Worker (SW) positions allocated to the CPS department.

Findings:

- CPS conducted five mass hiring events in 2016 filling more than 40 vacancies between July and December.
- CPS has also held joint labor-management meetings to collaborate and gather input and ideas from unions about employee morale and retention.
- Based on feedback collected during exit interviews of staff that left CPS service, the top two reasons for leaving were workload and support/training.
- CPS reports that hiring in cohort groups has given new staff the opportunity to develop peer groups and support mechanisms resulting in increased morale. Providing comprehensive, program-specific training and delaying case assignments has also increased morale as new SW staff are more informed and prepared before they go out into the field. Assigning peer mentors

to new SW staff has also led to increased employee morale. Only one employee from the cohort group that started last January has left CPS service.

Plan:

The CPS Oversight Committee will review and address staffing issues, as needed.

2015 Recommendation 3 (from CI Subcommittee): Board of Supervisors request CPS to ensure that stronger drug and alcohol policies are put in place, that CPS workers have the resources needed to evaluate caretaker substance abuse (training, ready access to testing, consultative support, etc.), and that caretaker substance abuse is elevated to high risk when formulating the "Safety Plans."

Findings:

- The Workforce Development Unit provided a class, *Alcohol and Drugs in the Youth Population*, to the most recent SW cohort. Also included in the Alcohol and Drugs (AOD) classes offered through the Workforce Development Unit is *AOD – Signs of Use Identification*.
- With the recent passing of California Proposition 64 (Marijuana Legalization Initiative), CPS reports they will review all policies and procedures, ensure all staff are trained, and policies (including those concerning visitation) are aligned to address marijuana and safety.

Plan:

The Oversight Committee will continue to advocate for stronger drug and alcohol policies.

2015 Recommendation 4 (from CI Subcommittee): Board of Supervisors review funding for Public Health Nurses and provide the necessary funding to the Division of Public Health to increase the number of PHNs dedicated to both child maltreatment intervention (in collaboration with CPS) and prevention (field nursing).

Findings:

- As a result of the FY16/17 Final Budget, the Division of Public Health gained four PHNs to work in Foster Care programs. In addition, CPS is adding two registry RNs to the Centralized Placement Unit, to bring the total to six registry RNs to provide assessments to new and AWOL return youth who are pending placement.
- There are 25 PHNs working in CPS, four of whom are registry nurses working in the Foster Care Program. CPS PHNs are assigned to the ER, Permanency, Court Services, Adoptions and CPSU programs.
- The State allocated new PHN funding for oversight of psychotropic medication which will equate to 1.5 psych med PHNs. CPS and PH management met recently to discuss hiring.

Plan:

The CPS Oversight Committee will continue to advocate for PHNs resources to be available to SWs staffing the Hotline room and for PHN involvement to continue after case closure, as needed.

2015 Recommendation 5 (from Systems Review Subcommittee): (Regarding Extended Foster Care (EFC) program) More accountability and more structure for the NMDs, incorporating input from SWs, attorneys and providers.

Findings:

- With the implementation of the EFC Court, CPS reports they have seen far more accountability for NMDs specific to the eligibility criteria. In addition, SWs are providing more details around active engagement efforts in court reports. SWs were also provided information on how best to collaborate with Children's Law Center and ensure proper documentation for court. Having one court has provided the SWs with consistent expectations allowing CPS to continue to hold youth and themselves accountable with the hope of improved outcomes.
- With the addition of two more ILP Youth Advocates (for a total of three – one working specifically with Expectant and Parenting Youth (EPY)) in the Independent Living Program (ILP), CPS has structured their positions so that they are the Subject Matter Experts of the services available to ILP youth in our community. The Youth Advocates also assist SWs in linking youth to the services they are eligible to receive, while providing more support and structure for youth struggling with the motivation to access such services. It has enabled many youth to meet the criteria. It has also provided additional support to CPS' recommendations to terminate the dependency of some by ensuring that youth who do not meet the criteria are aware of the services they are eligible to receive, should they decide they are ready to accept recommended assistance.

Plan:

The CPS Oversight Committee will review and address as needed.

2015 Recommendation 6 (from Systems Review Subcommittee): (Regarding Extended Foster Care (EFC) program) Increased coordination and collaboration among attorneys, SWs, Probation Officers, the Regional Center System and Mental Health.

Findings:

- CPS coordinated a meeting with the EFC supervisors, Program Managers and Alta Regional to increase mutual understanding and expectations of each agency. Some agreements were formulated around collaboration and how to best handle an inability to get in touch with an Alta Regional and/or EFC SW. The group discussed required documentation that the parties could potentially have access to, procedures for placements, and services delivered. The information was then provided to SWs during a unit meeting and has improved working relationships between the parties involved.
- CPS reports Alta Regional has been present at Team Decision Meetings (TDMs) and is coordinating much better with the EFC SWs. Understanding the services and barriers that effect how services are delivered was helpful to both parties in improving collaboration.
- An EFC Probation Officer is co-located with the EFC SWs. This has allowed for increased collaboration and better access to services for Crossover Youth, since resources can be shared. In addition, a new Crossover Youth Practice Model (CYPM) has been developed.
- CPS has recently added two new mental health providers that attend their monthly ILP Advisory meeting, a wraparound provider, as well as a representative from the Transitional Age Program. Knowledge is shared about services offered, referral process, and eligibility. This

has improved the mutual understanding of the whole picture for CPS youth struggling with mental health issues.

Plan:

The CPS Oversight Committee will review and address as needed.

2015 Recommendation 7 (from Systems Review Subcommittee): (Regarding EFC program) Annual resource fair that all Non-minor Dependents (NMDs) should be required to attend in order to identify the available resources.

Findings:

- CPS reports they are doing many things to ensure that those working with their NMDs have the knowledge and access to the services in our community for which they are eligible. CPS holds a monthly ILP advisory committee with community agencies and interested stakeholders to ensure youth are aware of and have access to a variety of services. EFC and ILP SWs working directly with youth also attend. Presentations from various agencies providing Transition Age Youth (TAY) services are given at each meeting. This committee is hosted by the County.
- CPS also reports there have been active efforts to discover and vet new agencies. CPS Youth Advocates via AmeriCorps have been working to become "experts of our community." They have worked to provide the SWs easily accessible folders of resources for our youth. They visit community agencies to bring back resources and determine the youth friendliness of agencies. They have assisted in providing referrals, transporting youth to programs, and providing knowledge of resources to CPS SWs. CPS Youth Advocates attend emancipation conferences in an effort to assist youth as they continue to make this transition to adulthood. They provide education around EFC and also provide referrals to services.
- In October, Sacramento County worked collaboratively with ILP contracted providers and other community agencies such as Court Appointed Special Advocates (CASA), Center for Employment Training, and American River College to host a Health, Education and Career conference that included a resource fair. Several agencies participated. Unfortunately there was low youth attendance. It was reported that local school districts have also hosted resource fairs with very low youth attendance. Sacramento County partnered with the Youth Engagement Project and identified a goal of increasing engagement of youth in ILP in an effort to ensure their commitment and participation in collaborative events that provide the youth with the knowledge and access to services that they need. As they enter the early phases of the project, they are gathering feedback directly from the youth, the adults working with them, and community partners. Upon review of the feedback, the project will be designed with new programs, outreach and engagement strategies. The "end-of-the-year-goal" is to host a large ILP event which includes a resource fair employing the improved methods of engagement and outreach in hopes for better participation.
- CPS has hired an ILP SW who will be partnering with iFoster to implement the job readiness program in Sacramento County. The iFoster jobs program matches employers with entry-level positions to foster youth who have been specifically trained, provided with adequate resources and ongoing coaching and support. This SW will provide 32 hours of employment skills training through an identified curriculum that youth must complete prior to being matched with a potential employer. The curriculum consists of job skills, soft skills, and life skills training.

In addition, this worker will provide ILP services, referrals to services, education, and assisting in hosting events for ILP eligible youth to include NMDs.

Plan:

The resource fair issue appears to be addressed. The CPS Oversight Committee will review and address EFC as needed.

2015 Recommendation 8 (from Systems Review Subcommittee): (Regarding EFC program) A far more structured approach to the initial process for NMDs with accountability measures implemented.

Findings:

- The NMD Court was established in April 2016. The presiding judge oversees this courtroom.
- CPS established a new process whereby the supervisors of the EFC units attend court and act as Court Officers for these hearings.
- CPS reports they have seen many benefits from this approach. Having all cases heard in one courtroom allows them to fully understand the consistent expectations of this courtroom.
- CPS reports that over the course of the last several months they have been able to quickly troubleshoot problem areas identified by the presiding judge regarding issues such as corrections to the Findings and Orders, increasing the detail of engagement efforts in court reports, increasing collaboration with Children's Law Center, and holding youth accountable to the expectations of the EFC program in a more timely fashion.
- Having CPS supervisors in the courtroom allows them to share their expertise about the nuances of the program with the court, allowing for more informed decisions. It has also allowed for a more fluid relay of information to the SWs leading to timely changes to practice encouraged by the court. CPS has established a more collaborative atmosphere with the court that seems to be benefiting the NMDs.

Plan:

The CPS Oversight Committee will review and address EFC as needed.

2015 Recommendation 9: All dependents of CPS have the same level of intervention/attention that is being afforded to the Commercially Sexually Exploited Children (CSEC) population.

Findings:

- CPS expressed that they agree all children and youth need high levels of intervention and attention focused on their particular needs.
- Continuum of Care Reform (CCR) brings opportunity for increased levels across the board:
  - A process is being developed to conduct required Child and Family Teams (CFTs) within 60 days for every child or youth that comes into care.
  - CPS has employed a teaming approach with the restructuring of Team Decision Making (TDM) and Safety Organized Practice (SOP).
  - Representatives from the Division of Behavioral Health will attend the Permanency Management Team meeting to discuss collaboration on a new diversion program.
  - CPS is moving toward having TDMs, Multidisciplinary Teams (MDTs) and CFTs for all youth.

Plan:

This recommendation will continue to be a prime focus of the CPS Oversight Committee.

2015 Recommendation 10: BOS support technical solutions that would support the operations of CPS. These include software programs for more structured online storage and for the organization of Policies and Procedures (P&Ps). Make P&Ps available via mobile devices and create the ability for staff to participate in online interactive trainings.

Findings:

- In collaboration with the County's Department of Technology (DTECH), CPS reports they are researching various technologies to meet the identified needs of document storage, learning management software, training videos and policy and procedure development and distribution. The P&P Taskforce is working collaboratively with DTECH to select the most appropriate software solutions.
- The BOS approved CPS to purchase software for their P&Ps.
- In addition, an Administrative Services Officer II position has been approved. This position will be involved in the maintenance of the policy and procedure software. The hiring selection process will begin in mid-January 2017.
- During the DHA presentation, the Oversight Committee learned that DHA already has technical solutions in place could address the needs of CPS. DHA offered to work with CPS in implementing these needed solutions.

Plan:

The CPS Oversight Committee will monitor CPS' progress in implementing the technical solutions and also their collaboration with DHA.

2015 Recommendation 11: CPS completes their work on Policies and Procedures and submits a timeline to the CPS Oversight Committee.

Findings:

- The Department of Health and Human Services expressed their commitment to strengthening its existing infrastructure in the development of policies and procedures with assistance and consultation services by Resource Development Associates (RDA).
- In September 2016 and October 2016, RDA delivered a policy-writing training to program planners and program specialists in order to build the Department's capacity in policy writing.
- In December 2016, the Department allocated three program specialist positions to be dedicated policy writers and CPS believes they will make more significant progress over the course of the year. They will begin in late January, undergo P&P training and then delve into the work.

Plan:

Policies and procedures issues have been a long standing concern to this committee; this will continue to be a prime focus until completion.

2014 Annual Report Recommendations

2014 Recommendation 1: Complete P&Ps within designated timeframe.

Findings:

- In late October 2016, the CPS Workforce Development Unit in Program Administration was fully staffed with one planner position, three specialist positions and two support staff positions to provide or coordinate training for CPS staff. In addition, the Workforce Development Unit works closely with designated division wide trainers to coordinate, develop and deliver trainings. Consultation and collaboration with Sacramento County Counsel is required for all trainings in order to ensure legal compliance. The Training Leads/Policy Writers are the subject matter experts on social work practice.

Plan:

The CPS Oversight Committee will continue to monitor progress.

2014 Recommendation 2: Permanency and Court Services are fully staffed with experienced SWs.

Findings:

- Court Services stability has been achieved and staffing levels have remained stable. The stability is closely monitored through data collection and enhanced attention to staffing levels, hiring needed and program needs so that CPS does not find themselves in the same situation again.

Plan:

The CPS Oversight Committee will review and address staffing as needed.

2014 Recommendation 3: Prioritize and fully resource the Continuous Quality Improvement (CQI) process through staffing, training and data systems so that it becomes an ongoing and integrated part of CPS.

Findings:

- All CQI-related positions housed within CPS Program Administration, ER, and Permanency have been filled. However, two of the three CQI positions housed within Program Administration have been temporarily shifted to assist with the mandated 25 quarterly Child and Family Services Reviews (CFSR). As of January 2017, there were two new CFSR staff pending background clearances before start dates can be confirmed. Once start dates are established, the new appointees would need to successfully complete CFSR certification training via the Northern California Training Academy as well as in house training to get acclimated to CPS and the CFSR process.
- CPS anticipates that their Program Administration's CQI staff will return to regular duties in May of this year.

Plan:

The CPS Oversight Committee will review and address as needed.

2014 Recommendation 4: As part of the QIC, develop a proactive plan for measurements to be put in place so that changes made can be measured to determine whether that change resulted in the intended improvement.

Findings:

- Safety Plan and Body Check Qualitative Reviews were conducted in November 2016-December 2016. The purpose of the review is to gather information regarding current practice in conducting Body Checks and developing Safety Plans, and to identify strengths and areas needing improvement in the systemic level. Reviews were conducted by ER Program Specialists.
- In alignment with CQI Framework and in an effort to develop a proactive plan to measure outcomes aimed at determining whether an intervention resulted in the intended improvements, the QIC Root Cause Matrix and the QIC Recommendation Tracking Log were created in May 2016.
- The previous Recommendation Matrix documented a list of recommendations (interventions) aimed at increasing safety. However, the recommendations/interventions tended to be narrow in scope and were compliance driven (i.e.: Was the task completed?). Additionally, this tracking mechanism did not capture information about how the recommendation/intervention resulted in the intended improvement and thereby increased safety.
- The Root Cause Matrix was developed, from a review of the previous Recommendation Matrix, in an effort to identify themes and establish measureable outcomes.

QIC Root Cause Matrix

Objectives:

- *To systematically identify and determine underlying causes that may contribute to child fatalities or near fatalities. Answer the questions: 1) Why was the child harmed; and, 2) What can the agency do differently to prevent future harm?*
- *To translate themes into CQI studies to better assess systemic issues and develop strategies to create targeted interventions.*

Four themes (underlying causes) have been identified from a review of the 2015 QIC Recommendation Matrix and the 2016 recommendations to date. The themes are as follows: 1) Assessment/Critical Thinking; 2) Engagement; 3) Intervention; 4) Partnering with Community. Each root cause theme is accompanied by "sub-themes" and suggested outcome measures.

QIC Recommendation Tracking Log

Objective: To provide an internal feedback/follow up mechanism to ensure that QIC recommendations are addressed and identified tasks are completed timely.

The current tracking log includes the following: 1) Date of recommendation; 2) Specific recommendations made by the QIC; 3) Staff assigned; 4) Specific information about the progress of actions undertaken in response to recommendations.

An internal protocol establishing a timeline has also been developed:

- *Week 1 – Large QIC (Recommendations made by QIC members)*
- *Week 2 – Email follow up from Program Administration to those with outstanding action items*

- *Week 3 – Schedule meeting regarding existing action items*
- *Week 4 – Follow up meeting occurs (if needed)*

This is a continual process of the Quality Improvement Committee, recognizing that outcome measurements take time. Continued next steps include determining a mechanism in which it can be determined how the interventions (recommended changes) resulted in the intended improvements.

Plan:

The CPS Oversight Committee will review and address as needed.

2014 Recommendation 5: Support the creating of a CPS Training and Staff Development Unit dedicated to training, technical assistance, case reviews, P&Ps, and lessons learned from QIC.

Findings:

CPS reported the following trainings have been developed and completed, or are scheduled:

- SW Standards and Division 31 Regulations *(completed)*
- Body Checks (combined with ER) *(completed)*
- Early Case Assignment/Matrix *(completed)*
- Court Services and Dependency Guidelines *(completed)*
- TDM Observations *(completed)*
- Permanency Overview *(completed)*
- JV 220 (psychotropic meds) *(completed)*
- CYPM Overview Training *(completed)*
- CYPM 101 (UC Davis provided across the Division of CPS) *(completed)*
- SW Safety Training (provided to all programs) *(completed)*
- Visitation Changes for New Legislative Updates *(completed)*
- Substance Abuse Resource Training for Youth *(scheduled for December 2016, was rescheduled)*
- Mileage and Travel *(scheduled for November 2016, was rescheduled)*
- EFC/ILP *(scheduled for February 2017)*

Plan:

The CPS Oversight Committee will review and address as needed.

2014 Recommendation 6: Implement recommendations and changes initiated as a result of the QIC and CI subcommittee case reviews:

There were five recommendations made by the CI Subcommittee in the 2014 Annual Report:

1. Creation of a Domestic Violence (DV) protocol
2. Ongoing staff training on dispositions
3. Consideration of all CPS history when evaluating a case
4. Evaluating the child holistically, considering the risk of harm to a child when developing Safety Plans, including risks associated with drug use, mental health, and domestic violence
5. Progressive intervention and consequences for parents

Findings:

Please see findings for 2014 Recommendation 9 from the CI Subcommittee (page 22).

Plan:

The CPS Oversight Committee will review and address as needed. The CPS Oversight Committee remains particularly concerned with Domestic Violence and progressive intervention.

2014 Recommendation 7: Establish a consistent ongoing means for intentional interagency coordination of County departments such as Department of Human Assistance (DHA), Probation, and DHHS (including CPS, Behavioral Health Services (BHS), In-Home Supportive Services and Public Health (PH)).

Findings:

This was addressed in 2015 Recommendation 1 Findings (page 11).

Plan:

See 2015 Recommendation 1 Plan (page 12).

Recommendation 8: Continue to refine improvements within the CPS Call Center by decreasing wait times, consistent use of SDM hotline tools, and reviewing "evaluated out" dispositions.

Findings:

Regarding decreasing wait times:

- CPS reports they are working with DTECH to learn the functionality of their current VoIP communications system, with respect to producing data reports.
- Ongoing data review occurs and CPS reports it has resulted in continuous quality improvement via restructuring work schedules to meet the high peak call volume.
- Newly acquired positions are in the process of being filled and CPS anticipates it will enhance productivity, Hotline operations and reduce wait times.
- Additionally, CPS reports there have been process changes regarding hotline access.
- In an effort to expedite initial call response, CPS is reconfiguring their clerical staff to allow callers to speak to a live person instead of a recording at the onset of the call.
- The Hotline now has a Program Specialist assigned to Hotline operations to work with and support the Program Manager in the efforts toward improvements.

Regarding consistent use of SDM hotline tools:

- Approximately 40 SDM reviews by ER management were completed during 2016. The SDM reviews utilize an SDM review tool that assesses the consistency of use of SDM Intake assessment tools and the outcome of the referral designation for 10-day or immediate response times. The review is completed by assessing CWS/CMS information and the SDM Intake Hotline tool.
- CPS reports compliance was above 90 percent.
- The next SDM compliance review is underway.

Regarding reviewing "evaluated out" dispositions:

- CPS reports that Peer Review continues on a monthly basis (two Evaluated Out (EO) referrals per Hotline SW are randomly pulled and reviewed by the Hotline Supervisory team).
- Discussions take place in the Supervisor's meeting and direct training and coaching is applied via the Supervisor and/or Program Manager as appropriate.
- The Hotline Program Manager also randomly reviews EO referrals separate from the Supervisor reviews to provide an independent Quality Assurance mechanism.

Plan:

Considering that nothing has changed since the 2014 Annual Report, this will be a high priority for the committee in the coming year. The CPS Oversight Committee will monitor progress in decreasing wait times, the consistent use of SDM tools, and that there is a more in-depth review of cases that have been evaluated out.

2014 Recommendation 9: Implement Critical Incidents Subcommittee recommendations.

Findings:

1) Creation of a Domestic Violence (DV) protocol

    - A DV protocol has been established and is a component of the Emergency Response Investigations Policy and Procedure. Training on this policy was completed in April-May 2014.
    - In 2014 CPS partnered with A Community for Peace (ACFP), a domestic violence family resource center, and the Citrus Heights Police Department (CHPD) to address the needs, safety and emotional well-being of children exposed to domestic violence. Through a joint response by CHPD, ACFP and CPS to Law Enforcement, calls and CPS referrals regarding domestic violence are coordinated so that children are provided with effective, immediate and ongoing services to help keep them safe, violence-free, and on the path to recovery from the effects of domestic violence. Additionally, a designated CPS social worker, who is well-trained in domestic violence, has an office located in ACFP. The presence of a CPS social worker in ACFP is breaking down barriers to needed services for adult victims of domestic violence. *(Information taken from the May 19, 2015 DHHS Response to CPS Oversight Committee's 2014 Annual Report)*
    - CPS reported that their Executive Management Team completed DV training on August 27, 2014 followed by ER staff on August 28 and 29, 2014. Training occurred for Permanence Staff of September 18, 23, and 24, 2014. DV training is an ongoing component of Cohort Training for New Social Workers. The following DV resources, used as a guide for critical thinking, were developed, trained to, and provided to staff during the training dates outlined above: 1) DV Intervention Sheet and Safety Plan; and, 2) DV Field Sheet.

2) Ongoing staff training on dispositions

    Findings:

    - CPS reported that disposition trainings took place with ER, Informal Supervision (IS), and Court Services in August and September 2016. Additionally, disposition training for new

SWs occurred in November 2016 and is an ongoing component of cohort training for new SWs.

- A pilot project introducing Disposition Trees was developed in June 2014 as an additional critical thinking resource. The trees were developed as a mechanism to clarify penal code definitions concerning child abuse and neglect and to adequately apply the information to referral dispositions.

3) Consideration of all CPS history when evaluating a case

Findings:

- CPS reported that the review of prior case history in CWS/CMS was included in the ER Supervisory Academy which took place in August 2014. The Academy emphasized the importance of reviewing prior case history by gathering relevant documents and reports and using this information during the investigation. Further importance was focused on the use of case discussion within the units.
- The ER Supervisors Academy reiterated the importance of not only looking at prior case dispositions, but reviewing prior case reports to identify potential patterns of behavior that are indicative of abuse and neglect.

4) Evaluating the child holistically, considering the risk of harm to a child when developing Safety Plans, including risks associated with drug use, mental health, and domestic violence

Findings:

- CPS reported that the Emergency Response Policy & Procedure was strengthened and these factors are specifically delineated in the Safety Plan and the Family Safety Planning Policy & Procedure that was updated on January 5, 2016. Training on this policy was provided to all SWs in January and February 2016.
- Field Resources were developed for SWs to address safety related issues regarding drug use, mental health, and domestic violence as outlined below:
  - DV Intervention Sheet and Safety Plan
  - DV Field Sheet
  - Alcohol and Drug Services Interview Guidelines
  - Safety Planning Considerations with Victims and Children

5) Progressive intervention and consequences for parents.

Findings:

- The Informal Supervision Policy and Procedure has been updated, clearly outlining the following: 1) Expectations for closure; 2) Assessment of a parent's progress; and, 3) Intervention strategies when faced with parental non-compliance.
- CPS reported that their ER Program Managers conduct case reviews for all referrals that have "very high" SDM risk assessments prior to closure to ensure all safety factors have been addressed, all interventions align with the assessment, and safety threats have been mitigated.
- CPS also reported that their Program Planners conduct case discussions with all ER staff, reviewing decision points on cases where a fatality or near fatality occurred. Highlights and discussions involve consideration of all CPS history, dispositions, progressive

intervention, safety planning, critical thinking, and decision making. These case review and ongoing discussions occur in small sessions with a supervisor and his/her direct reports.

Plan:

Due to the importance of this recommendation which includes five sub-recommendations, the CPS Oversight Committee will monitor and review and continue to receive feedback on the progress that is happening in CPS with respect to them. The job of a line SW is complicated and requires a lot of critical thinking. Progress in these areas continues to be impacted by high staff turnover, and inexperienced SWs and supervisors (inadequate supervision).

IV. Oversight Committee Recommendations

As a result of the observations documented in this report, the Oversight Committee recommends the following:

1. Provide the Emergency Hotline with PHN resources which could assist with determining response times and conclusions on referrals with allegations of medical neglect, and staff training around how to best utilize these resources.
2. Assign a PHN to every case that meets criteria, utilizing on-call, contract or registry nurses to fill the gaps as needed.
3. Develop the resources to allow PHNs to follow high-risk medical children after the cases are closed with CPS. Currently, PHN services to child/family cease once the CPS case closes.
4. Fully staff the Child Abuse Bureaus of local law enforcement agencies.
5. Provide additional mandated reporter training for DHA staff.

Continued recommendations from previous years:

6. Establish a Blue Ribbon Panel made up of members from Law Enforcement, Human Services agencies, District Attorney's Office, Probation, hospital systems, health plans, California Children's Service (CCS), Alta Regional Center, and community-based organizations to address better collaboration, identify gaps and offer solutions. This panel would mirror a similar panel approved by the BOS addressing the disproportional rate of deaths among African American children.
7. Board of Supervisors request that CPS ensure that stronger drug and alcohol policies are put in place, that CPS workers have the resources needed to evaluate caretaker substance abuse (training, ready access to testing, consultative support, etc.), and that caretaker substance abuse is elevated to high risk when formulating the Safety Plans.
8. All dependents of CPS have the same level of intervention/attention that is being afforded to the Commercially Sexually Exploited Children (CSEC) population.
9. CPS completes their work on Policies and Procedures and submits a timeline to the CPS Oversight Committee.
10. Make P&Ps available via mobile devices and create the ability for staff to participate in online interactive trainings.
11. CPS continues to focus on Domestic Violence and progressive intervention.
12. Continue to refine improvements within the CPS Call Center by decreasing wait times, consistent use of SDM hotline tools, and reviewing "evaluated out" dispositions.

V. 2017 Work Plan

- Meet new Ombudsman; receive overview of her work
- Continue to receive CPS Updates
- Continued CI case reviews
- Follow up on 2016 Annual Report recommendations
- Meet with Medical Neglect Review Team; receive overview
- Continue to collaborate with CDRT
- Develop collaboration efforts with child serving agencies such as California Children's Services (CCS), Alta Regional Center, school systems, and others
- Possibly begin investigation around the California Child Welfare Core Practice Model and how it is being implemented in Sacramento County

Appendix A: CPS Oversight Committee Membership

Roy Alexander, LCSW
Chief Executive Officer
Sacramento Children's Home

Karen Alvord, LCSW, MBA
Chief Executive Officer
Lilliput Children's Services

Michele Bell, MA
Permanency Supervisor, Child Protective Services
Department of Health and Human Services

Jane Claar, MSC, PPS
Coordinator, Child Welfare Attendance
Twin Rivers Unified School District

Joni Edison, MSW
Retired Program Manager, Foster Care Eligibility
Department of Human Assistance

Sister Jeanne Felion, SSS
Executive Director
Stanford Settlement Neighborhood Center

Maynard A. Johnston, MD, FAAP
Retired Pediatrician

Dr. Virginia E. Maulfair
Volunteer
Sacramento Court Appointed Special Advocates

Chris Ore
Supervising Deputy District Attorney, Special Assault and Child Abuse Unit
Sacramento District Attorney's Office

Sharon Rea Zone, LCSW
Infant Mental Health Program Manager, U.C. Davis C.A.A.R.E. Center
U.C. Davis Children's Hospital

Sergeant Tony Saika
Child Abuse Bureau
Sacramento Sheriff's Department

Christina Solomon, BSW
Emergency Response Social Worker, Child Protective Services
Department of Health and Human Services

Elizabeth Uda
Program Officer, Head Start Program
Sacramento Employment and Training Agency (SETA)

Appendix B: Annual Report 2015 and 2014 Recommendations (Full Text)

2015 Recommendations

From the Critical Incidents Subcommittee

1. That the Board of Supervisors develop a countywide commitment to encourage other departments – such as Law Enforcement, Mental Health, hospitals, and the courts – to become more aware and responsive to how their decisions impact the safety of children and the work of CPS, and collaborate better with CPS and each other (perhaps forming a Blue Ribbon Commission to address this issue).
2. That the Board of Supervisors support and encourage CPS management's efforts to improve employee retention, particularly around the issues of high caseloads and employee morale. What this support means is that there need to be more SW positions allocated to the CPS department.
3. That the Board of Supervisors request CPS to ensure that stronger drug and alcohol policies are put in place, that CPS workers have the resources needed to evaluate caretaker substance abuse (training, ready access to testing, consultative support, etc.), and that caretaker substance abuse is elevated to high risk when formulating the "Safety Plans".
4. That the Board of Supervisors review funding for Public Health Nurses and provide the necessary funding to the Division of Public Health to increase the number of PHNs dedicated to both child maltreatment intervention (in collaboration with CPS) and prevention (field nursing).

From the Systems Review Subcommittee

Regarding the Extended Foster Care program:

5. There needs to be more accountability and more structure for the NMDs, incorporating input from SWs, attorneys and providers.
6. There is a need for increased coordination and collaboration among attorneys, SWs, Probation Officers, the Regional Center System and Mental Health.
7. There are several community agencies, individual, and corporate donors that are committed to assist former foster youth. Much could be gained by convening all interested stakeholders to hold an annual resource fair that all NMDs should be required to attend in order to identify the available resources.
8. There needs to be a far more structured approach to the initial process for NMDs with accountability measures implemented. It is our understanding that there is now a special dependency court for NMDs which creates far more consistency, court activity and follow up with the assigned judge. This is a big step towards accountability and consistency in the message to the NMD.

Other

9. All dependents of CPS need the same level of intervention/attention that is being afforded to the Commercially Sexually Exploited Children (CSEC) population.
10. The BOS support technical solutions that would support the operations of CPS. These include software programs for more structured online storage and for the organization of Policies and Procedures (P&Ps). Also, we recommend making P&Ps available via mobile devices and the ability for staff to participate in online interactive trainings. Currently, this is not possible.
11. That CPS complete their work on Policies and Procedures and submit a timeline to the CPS Oversight Committee.

2014 Recommendations

1. Complete the Policies and Procedures (P&P) process within the timeframe designated. The Oversight Committee commends CPS for seeking external expertise in revising their P&Ps. However, this important effort needs to be fully realized in a timely manner so Social Workers have clear policies and procedures to guide their practice in ensuring children are safe.
2. Due to the particular complexity of Court Services, as part of the Court Stability Plan, CPS should ensure that Court Services is fully staffed with experienced Social Workers.
3. *Prioritize and fully resource the Continuous Quality Improvement (CQI) process through staffing, training, and data systems, so that it becomes an ongoing and integrated part of CPS, despite the pull to respond to other pressing issues.
4. As part of the Quality Improvement Committee (QIC), develop a proactive plan for measurement to be put in place so that changes made can be measured to determine whether that change resulted in intended improvement. The QIC staff, and other identified staff throughout the Division, should have specific training in the evaluation of continuous quality improvement and be able to guide the group in designing clear and objective ways of measuring the outcome of the recommendations resulting from critical incident reviews. Significant and thoughtful investment is needed to answer the following question, "How will we know that a change is an improvement to help keep children safe?"
5. *Support the creation of a CPS Training and Staff Development Unit dedicated to training, technical assistance, case reviews, Policies & Procedures, and lessons learned from QIC. The Training Unit should include a staff accountability component to ensure staff are getting training they need and are demonstrating improvement in knowledge and skills. Additionally, a Deputy County Counsel should be assigned to the Training Unit to contribute to and support improved Social Worker skills and practice including but not limited to: training on accuracy of dispositions, establishing fact patterns to get to the correct disposition, preparing court reports, reviewing policies and procedures to ensure alignment with regulations and legal requirements, and to review new legislation and regulations to inform practice and policy changes. As part of the training plan, CPS should continue to do case reviews with Social Workers and Supervisors as an effective form of training.
6. Implement the recommendations and changes initiated as a result of the QIC and Critical Incident Subcommittee case reviews.
7. Establish a consistent ongoing means for intentional interagency coordination of County departments that intersect in the lives of families and children. Coordinated interagency communication between Department of Human Assistance including government aide and domestic violence; Probation; Department of Health and Human Services including Child Protective Services, Behavioral Health, In-Home Supportive Services, and Public Health will decrease fragmentation and improve service delivery.
8. Continue to refine improvements within the CPS Call Center such as:
    a. Explore data driven innovative strategies to reduce wait times through expanding successful models being implemented;
    b. Improve the consistent use of SDM hotline tools for consistency in response times; and
    c. Review "evaluated out" dispositions to ensure accurate dispositions and address any training issues that may improve more accurate dispositions.

From the Critical Incidents Subcommittee

9. Creation of a Domestic Violence (DV) protocol
10. Ongoing staff training on dispositions
11. Consideration of all CPS history when evaluating a case
12. Evaluating the child holistically, considering the risk of harm to a child when developing Safety Plans, including risks associated with drug use, mental health, and domestic violence
13. Progressive intervention and consequences for parents

Appendix C: Presentations to the Oversight Committee (Full Text)

June 2016

California's Child Welfare Continuum of Care Reform (CCR)

Doug Johnson of California Alliance of Child and Family Services and David Ballard of Children's Receiving Home provided an introduction to California's Child Welfare Continuum of Care Reform (CCR).

- Senate Bill (SB) 1013 (approved in June, 2012) required that the California Department of Social Services (CDSS) consult with a number of stakeholder organizations to develop recommendations for revisions to the State's current system serving youth in foster care.
    - CDSS produced a report in January 2015 outlining a series of inter-dependent recommendations to improve assessments of children and families in order to make more informed and appropriate initial placement decisions, emphasize home-based family care placements of children, appropriately support those placements with available services, change the goals for group home placements, and increase transparency and accountability for child outcomes.
    - These recommendations would shift the purpose of group homes away from providing long-term placement for foster youth, to providing short-term residential treatment as an intervention. It would also provide targeted training and support to families who provide foster care so they are better prepared to care for youth living with them.
- Assembly Bill (AB) 403 (approved in October, 2015), also known as the Stone Bill, adopted and created a timeline to implement the recommendations from CDSS' 2015 report.
- The premise is that children who must live apart from their biological parents do best when they are cared for in committed, nurturing family homes. The goal for all children in foster care is normalcy in development while establishing permanent life-long family relationships with people who prepare them for a successful transition into adulthood.
    - One of the goals of CCR is to reduce placements in group homes and instead place youth in home-based family care with specially trained "Resource Families".
    - Group homes would be transformed into Short-Term Residential Treatment Centers (STRTC) where youth who are not ready to live with families can receive short term, intensive treatment.
    - Statewide implementation of the Resource Family Approval process will improve selection, training and support of families under a streamlined process for approving families (including relatives) seeking to care for a child in foster care, whether on an emergency, temporary or permanent basis. All families will receive training, services and supports by a Foster Family Agency (FFA).

Issues of concern around implementation of CCR were discussed. Questions were addressed.

- The plan is to implement this effort on January 1, 2017. This does not allow much time for providers to apply/become approved for FFA and STRTC status by the implementation date.
- Agencies currently providing temporary/emergency shelter for children may have their operations impacted if they are unable to become certified by the deadline.
- There are not enough resources to serve the current need for foster placement/temporary shelter; this shift could exacerbate the situation – at least in the short-term.

- Unintended consequences could include: resistance to change, loss of provider agencies, and disincentive for providers to do the work.
- Implementation may be a challenge due to the high needs of the youth stepping down from group homes into home-based family care. It may be a challenge to recruit people to do the level of work needed – both in the service provider and Resource Family realms.
- Where does the funding for this reform come from?
    - The State has set aside General Fund dollars based on their cost estimates (new rates paid to providers will be higher than current rates). The theory is that over the long term, the costs will be around the same. It will cost more up front but the net cost should not be higher – and better outcomes for children and families would be achieved. Additional County General Fund dollars have also been requested.

CPS Deputy Director Michelle Callejas was invited to give a presentation at the July 20, 2016 Children's Coalition's General meeting on the work Sacramento County has been doing around this issue. Oversight Committee members were invited to attend the meeting to learn more information.

September 2016

Sacramento County Public Health Nurses (PHNs): Review of Services and Recommendations

Sacramento County Public Health Officer Dr. Olivia Kasirye, CPS Acting Heath Program Manager Angie Butters, CPS Program Planner Cynthia Vanzant and CPS/Public Health Nurse Supervisor Blanca Gomez educated the committee about the CPS PHN continuum of services.

- Over time, Public Health has become aware of the need to be more involved with CPS. Many health issues can be tracked back to adverse childhood experiences.
- PHNs working within the Sacramento County Child Welfare System work side by side with Social Workers and provide their services to the following five programs: Emergency Response/Informal Supervision (positions funded by CPS), Court Services (positions funded by CPS), Dependency (positions funded through California State Child Health and Disability Prevention Program (CHDP)), Adoptions (positions funded through CHDP), and Probation (positions funded through CHDP).
    - The Division of Public Health provides oversight for all PHNs within the Department, however supervision of the PHNs working within the Child Welfare System is provided by CPS.
    - All positions within each program were reported to be filled (with the exception of a 0.5 FTE in ER/IS which was expected to be filled soon after this presentation).
- Emergency Response/Informal Supervision (ER/IS) PHNs provide direct services to CPS clients and family members, as well as consultation to CPS Social Workers (SWs) regarding medical or health issues. SWs make referrals to PHNs to assist with stabilization of medical issues and development of follow-up plans to ensure the safety of the child.
    - Some examples of cases ER/IS PHNs assist with: children with autism, autoimmune disease, cerebral palsy, Type 1 diabetes, mental health issues, untreated dental decay, spina bifida, malnourishment, chronic homelessness, premature babies, high consumers of pediatric and specialty care, and children fed through a trach tube.
    - PHNs also participate on the Medical Neglect Review Team where they conduct nursing assessments, provide interventions, refer to appropriate services and assist in identifying follow-up care to ensure the safety of the child.

- PHNs meet twice a month with SWs to review cases that involve medical neglect. The PHNs provide consultation about health issues and answer questions. This also provides an opportunity for the SWs to bring cases that are in need of linkage to services.
- Alta California Regional Centers and California Children's Services send representatives to review cases with the ER Team, ensuring cases are linked appropriately and identifying any issues in need of addressing.
- Data around the number of referrals to this program does not paint the whole picture; it does not take into account the amount of time it takes to work each case. Working cases is time and labor intensive and involves non-direct services such as troubleshooting Medi-Cal and researching/linking clients to available services.
- The needs for this program exceed the available resources. At least one or two more full-time PHNs are needed to meet the need.

- Court Services is a collaboration between CPS, Public Health, Behavioral Health and Sutter Health.
  - Over 400 cases were received by Court PHNs in the five months prior to this presentation, which was spread between two PHNs. This area has been identified as a high priority for directing more resources at this time. The expectation is that PHNs will see all children referred to this program, interview families, contact care providers, inform on urgent issues and medical/dental homes, gather records, work with court investigators, start a health and education passport (used for all placements) and enter information into CWS database. A third PHN will be hired soon and efforts are being put in place to receive more clerical support to alleviate the administrative work, but it is still unclear if this will be enough to serve the need.
  - Last year 650 children were referred to the HEARTS for Kids (H4K) program. All children referred saw a nurse practitioner and received a clearance exam, but not all were able to receive a home visit due to limited resources. Approximately 200 children did not receive home visits. However, all children were referred to Behavioral Health early intervention programs, which do home visits, help keep placements intact, and help with behavioral issues which result from past trauma.
    - Referrals to this program were low at the time of this presentation. In times of higher need, ER PHNs are able to assist the H4K program. H4K PHNs are not able to assist the ER/IS program, however, due to funding restrictions (funded by First 5 Sacramento).
- As services with the Court Services program end, cases are moved to the Dependency program. Dependency PHNs/RNs provide ongoing care coordination until Dependency is terminated.
  - There is a need for more nurses to assist the work of this program. Currently there are unassigned cases due to the high volume of children in this program.
  - There are no resources to provide field nurses to assist with home visits after cases move out of the Court Services program (Home visits are only provided by ER/IS and H4K PHNs). Dependency, Adoptions and Probation nurses are not able to provide home visits due to funding restrictions (funded by CHDP).
  - CPS is piloting a program where RNs are sited at the Centralized Placement Services Unit (CPSU) to assess all youth removed from the home, triage youth experiencing a health issue and make referrals on the spot. They also develop discharge summaries, provide consultation and education with patients and foster parents, and administer medication.
  - The pilot began in July 2015 and so far, has been a huge success.

    - Over the last four months, an average of 349 assessments and 311 consultations were conducted per month.
    - Currently there are four RNs staffing the program and two more will be hired soon.
- If more funding for PHNs were granted:
    - More home visits could be provided.
    - More early intervention services could be provided by ER and Court PHNs which would help alleviate the work, as issues could be addressed on the front-end before they are escalated to a level that would require more resources to resolve.
    - A greater level of service could be provided to consumers of CPS Court Services.
    - PHNs would be able to provide more training to Social Workers regarding signs to look for with medically fragile children, commonly used medical equipment, and high-level overview/useful information about conditions commonly seen.

A recommendation from the 2015 Oversight Committee was for the Board of Supervisors to review funding for the Division of Public Health to increase the number of PHNs dedicated to child maltreatment intervention (in collaboration with CPS) and prevention (field nursing).

As a result of the FY16/17 Final Budget, the Division of Public Health gained four PHNs to work in Foster Care programs. In addition, CPS is adding two registry RNs to the Centralized Placement Unit, to bring the total to six registry RNs to provide assessments to new and AWOL return youth who are pending placement. The addition of these nursing resources dedicated to child maltreatment intervention is welcomed.

The only PHN services available to the community (outside of CPS PHN services) are the family nurse partnership, which serves a targeted population only. Once a CPS case closes, no further PHN services are available. There is no safety net of PHN services to provide services to non-CPS cases. A field nursing unit to serve the community (including closed CPS cases) is still needed. Prior to cuts necessitated by the budget shortfalls, Sacramento County provided field nursing services funded by a combination of General Funds, realignment, and matching federal funds for Targeted Case Management. A field unit of PHNs would be a resource that could reduce entry and re-entry into Foster Care by providing prevention and aftercare services to vulnerable children and families.

CPS PHN CONTINUUM BY PROGRAM

Contacts
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	ER/IS	COURT	DEPENDENCY	ADOPTIONS	PROBATION
Number of PHN's	4.5 FTE: **Home Visits**	**A. HEART 4 KIDS** 3.5 FTE: **Home Visits** **B. Court PHNs** 3.0 FTE	6.3 FTE	1.0 FTE	.5 FTE
Services Overview	The PHN assists SW's with investigation of allegations of child abuse on referrals which have health medical concerns/ conditions. The goal is to assist with stabilization of medical issues and assist with development of follow-up plans to ensure the safety of the child. The PHN provides direct services to CPS clients and appropriate family members such as conducting home visits, and coordination of medical services. The PHN is also available for consultation to SW's about medical or health issues. Attend TDM and MNRT as needed.	A. Provide health insurance screenings, referrals to routine physical and dental exams, assist to obtain and establish with medical homes, and to facilitate prompt treatment of urgent medical issues for children up to the 6th birthday. PHN's will conduct physical & development assessments, and refer to the Mental Health Early Intervention program for mental health assessments. B. Interviews parents prior to det. hearing to gather health information and obtains medical releases. Contacts community providers for health information and initiates the HEP. Addresses urgent issues and communicates critical information to caregivers. Collaborates with Court Services.	Provides ongoing care coordination until Dependency is terminated. Obtains medical records from providers. Monitors and assures annual exams are up to date. Conducts case management for children with chronic medical concerns. Provides health education and resources information to caregivers and Social Workers (SWs). Attends Team Decision Making (TDM), MNRT meetings for children with complex health conditions as needed.	Provides on-going care coordination the life of the case while in Adoptions. Conducts follow up of medical concerns and provides health education to caregivers and SW. Monitors and assures annual exams are up to date. Participates in disclosure meetings for children with complex health conditions.	Target Population: Probation youth in out of home placement Initiates and monitors HEP Reviews medical records, including psychotropic medications Provides consultation to Probation Officer regarding minor's medical/health conditions Coordinates care to ensure continuity of care and positive health outcomes.
	Ages 0-18 years	A. Up to 6th birthday B. Ages 0-18 years	Birth to18 years	Ages 0-18 years	Probation Youth under 18
Services Timeframe	ER- Investigation up to PC or referral closure. IS – As needed and completion of nursing care plan.	A. PC up to 6 weeks B. Detention hearing up to 6 weeks.	From 6th week of detention/closure by Court PHN until case is closed, transferred out of county or out of Dependency / Court Supervision.	From initiation of services until adopted and/or CPS termination.	Upon release from Juvenile Hall until end of Probation.

Guardianship and AB12: No PHN's assigned, however foster care nurses are available for general consultation only.

CENTRALIZED PLACEMENT SERVICE UNIT
NURSING SUPPORT (Registered Nurses)

PILOT-2015

Services Overview

The RNs conduct full head to toe assessments on all children that enter into custody. The goal is to ensure that all of the youth's medical needs are met. The RNs consult with child welfare staff, doctors, hospital staff, and foster parents. They administer medication for all youth that enter care who bring their labeled medication with them. The RNs triage any youth who might be experiencing a health issue and make referrals to Urgent Care, ER, or follow-up with their PCP. The RNs develop a discharge plan for youth who received medical treatment during their stay at CPSU.

Number of RN's: 4.0 FTE contracted through nursing registry
Services Timeframe: Monday through Friday: 7:00 am to 11:30 pm (2 RNs)
Saturday through Sunday: 3:30 pm to 11:30 pm (2 RNs alternate weekends)
Currently in the process of hiring 2 RNs to work alternate weekend shifts to cover 7:00 am to 3:30 pm shift

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October 2016

Child Abuse Prevention Center Chief Program Officer Stephanie Biegler and Child Death Review Team (CDRT) Chair Marian Kubiak provided an overview of the Sacramento County CDRT 2013-2014 Report presented at the October 4, 2016 Board of Supervisors (BOS) meeting.

- The mission of the CDRT is to: review all child fatalities of Sacramento County children age 0-17; enhance the investigation of all child deaths through multi-agency review; develop an aggregate description of all child deaths to identify cause of death, including abuse/neglect; and develop recommendations for the prevention and response to child deaths based on the reviews and aggregate information.
    - Participants of the CDRT and related committees include representatives from Sacramento County Departments of Health and Human Services (DHHS) and Human Assistance (DHA), Probation Department, Sheriff's Department, District Attorney's Office, Coroner's Office, Law Enforcement Chaplaincy, First 5 Sacramento, Robla, Sacramento City, Twin Rivers, Natomas, Elk Grove and San Juan Unified School Districts, Elk Grove, Sacramento City and Citrus Heights Police Departments, California Highway Patrol, Sacramento Metropolitan Fire District, Sacramento City Fire Department, UC Davis and Mercy San Juan/Dignity Health Medical Centers, Kaiser Permanente, Sutter Health/Sutter Medical Foundation, WellSpace Health, Center for Community Health and Well-Being and WEAVE.
- In 2013-2014, 261 children age 0-17 residing in Sacramento County died (average death rate of 36.4 per 100,000). This is a decrease from 409 children stated in the 2010-2012 CDRT Report (average death rate of 38.1 per 100,000). The total County and non-County resident child decedents in Sacramento was 265.
    - 196 (75%) were natural; 55 (21%) were injury related; 10 (4%) were of undetermined manner
    - The leading causes of death were perinatal conditions (77 or 29%), congenital anomalies (61 or 23%), infant sleep-related (28 or 11%), and homicides (28 or 11%).
    - 83% (221 of 265) of all child decedents had at least one risk factor. This is an increase from 76% (208 of 275) in 2009-2010.
        - Risk factors tracked include: family history of alcohol and/or other drug abuse, family history of violent and/or non-violent crime, decedent enrolled in government aid programs, decedent or family history involvement with Sacramento County CPS, family history of domestic violence, and family history of mental health issues.
    - Child maltreatment was involved in the deaths of 28 children – 16 of which were Child Abuse and Neglect (CAN) homicide.
        - 76% of CAN homicide perpetrators were the parent
        - Risk factors were known to be present in 94% (15 of 16) of CAN homicides
        - The CDRT found a significant correlation between a family history of receiving TANF and CAN homicides, as well as CPS involvement and CAN homicides.

Issues of concern were discussed. Questions were addressed.

- According to the report, there were a total of 11 suicides listed under Injury Related causes of death and 55% (6 of 11) had a history of mental health issues. For the next report, a recommendation is to drill down even further to include the number of children who had a history of psychiatric hospitalization.
- Is there a way to enforce consequences for families with risk factors and who are not utilizing the available resources to decrease these risk factors? A major concern of the Critical Incidents (CI) subcommittee is that there are no consequences for lack of participation.

- Participation in resource programs is voluntary, however, it can be strongly encouraged and the positive outcomes achieved by participation can be reinforced at various levels and through various points of service.

- What are other community groups doing to address the prevention of child deaths in the Sacramento community?
  - The BOS formed a Blue Ribbon Commission around the disproportionate death rate of African-American children in Sacramento County (23%, or 61 of 261, in 2013-2014). The Reduction of African American Child Deaths (RAACD) project resulted from the Blue Ribbon Commission's recommendations. The project involves multiple County agencies, First 5 Sacramento, the City of Sacramento, large and small community organizations, and seeks to reduce the number of CAN homicides, third party homicides, infant related, and perinatal related deaths in targeted high-risk neighborhoods.
- How do Sacramento County's statistics compare to other county statistics?
  - It is difficult to compare, as other counties do not provide the same level of investigation. There are, however, efforts to provide some standardization across the country, currently.

November 2016

Collaboration with Local Law Enforcement, Sacramento Police Department (PD)

Sergeant Patrick Kohles of Sacramento Police Department's Office of Investigations provided an overview of how the Department's Child Abuse/Sexual Assault Unit responds to and investigates child abuse and sexual assault.

- The Office of Investigations is responsible for developing information leading to the arrest of criminal offenders. It includes Detectives, Forensics, Public Safety IT, Records, Evidence and Property. The Child Abuse/Sexual Assault Unit not only investigates incidents of child abuse (for children under the age of 14) and sexual assault (all ages), but it also provides outreach and education to the community, reinforcing good safety precautions as well as the importance of having a plan and being aware.
- When calls regarding child abuse/sexual assault come in, a patrol officer is the first to respond. Their initial contact with the victim includes:
  - Obtaining statements – Statements are obtained from victim(s) and witness(es). This may include the reporting party, parents/caregivers, teachers, counselors, classmates, siblings and neighbors. Child victims are not asked to share details at this time; the goal is to conduct only one interview with the child to mitigate the trauma of having to repeat the story more than is necessary. Suspects' statements are generally not obtained at this time, unless they are on site (this allows investigators to review evidence prior to taking the suspect's statement).
  - Observing injuries – Immediate danger is assessed and injuries are documented. The #1 priority is the safety of the child.
  - Collecting evidence – There is a strong focus on the collection of evidence. Officers collect a variety of physical evidence in order to build a case. Evidence collected may include bedding, clothing, carpet samples, pictures, personal items such as diaries, letters, cards and jewelry, and computers (may do a forensic examination for digital evidence).
  - Evidentiary exams – Victims are referred to the Bridging Evidence Assessment & Resources (BEAR) Center for child abuse assessment (including physical abuse and neglect), forensic medical examinations for sexual assault, and connection to community resources. DNA

evidence may also be collected from the suspect. Forensics examiners are contacted to set up interviews with the victim(s) and the suspect.
        - Processes are in place for expedient collection and testing of sexual assault kits, as well as entry into the database. In Sacramento, kits are picked up and tested within 5-7 days.
    - Cross reporting to CPS – Police officers are mandated reporters, and as such must report all suspicion or evidence of child abuse to CPS. The report to CPS is documented in the police report. Sacramento PD also takes additional steps to ensure the safety of the child and collaboration with CPS.
        - CPS is often called to find out if the child, parent, or caregiver has CPS history.
        - Officers take the child victim into protective custody, if necessary. Patrol officers are instructed to err on the side of caution – if there is any concern for the child's safety they are to be placed in protective custody.
        - Reports are written and filed detailing the incident and documenting contact with CPS. Form 11166 Suspected Child Abuse Report is completed, filed and copies are submitted CPS, the District Attorney's Office and the reporting party.
    - Pre-text phone call – Recorded phone calls between the victim and the suspect, usually initiated by the victim, under the supervision of the officer, can be used to solicit incriminating statements from the suspect. The recording resulting from an effective pre-text call gives the investigator leverage during the subsequent interview of the suspect because the investigator can confront the suspect with the statements the suspect made during the call.
- The job of the Investigator/Detective is to build a prosecutable case that can be proven beyond a reasonable doubt, and they work closely with the District Attorney's Office on cases.
    - Victims are interviewed, taking into consideration their emotional condition.
    - Accusers and witnesses are interviewed – and sometimes are re-interviewed to prove or disprove allegations. False allegations are often made by parents involved in a child custody battle.
    - Evidence is collected, reviewed and used to build a case. Search warrants can be issued to obtain additional evidence.
        - Probable cause arrests are not typical, as it reduces the amount of time required to prove the case to 48 hours – which is difficult to accomplish.
    - The suspect's name and information is run through various databases to check for previous criminal history.
        - Once the basis for a case is put together, the final interview is with the suspect. Polygraph exams may be used to analyze the physiological reaction of the suspect.
    - The case is then presented to the District Attorney, who will make final determination on whether to prepare and file criminal charges in court against the alleged criminal perpetrator.
    - Detectives may also testify in court – in preliminary hearings and throughout the court process – and may even testify on what expert witnesses have reported.
- Sacramento PD's Office of Investigations works with many agencies in serving the children and families they come in contact with. They have collaborative relationships with CPS, hospitals, the District Attorney's Office, community-based services provider organizations, and other law enforcement agencies.
    - A CPS worker is out-stationed in the Child Abuse/Sexual Assault Unit's office five days a week, acting as liaison between the two agencies. This helps by expediting processes, educating staff about policies and procedures, and ensures effective and efficient

collaboration. Having the CPS liaison out-stationed in the unit's office is important to managing the volume of reports received by the unit.
    - Unit staff also participates in SCAN meetings – a multi-disciplinary approach where child abuse cases (sexual abuse, physical abuse, neglect and issues with newborns) are discussed to ensure the children are receiving the appropriate resources. The meeting typically consists of child abuse doctors from various hospitals (Sutter, Kaiser, UCD), CPS and local law enforcement agencies.

Issues of concern were discussed. Questions were addressed.

- Do all Patrol Officers have cameras?
    - Yes, typically – however they refer to Crime Scene Investigators to take pictures of the evidence, as they have access to better equipment.
- How many cases are investigated on a monthly basis?
    - Between January 1 and November 1, 2016, the unit has received about 1200 reports of child abuse.
- Are all 1200 reports investigated?
    - Yes, in some way or another. Some cases are referred to CPS for investigation (the reports that aren't investigated criminally are investigated by CPS). Cases that are not within the jurisdiction of Sacramento PD are referred to the appropriate law enforcement agency for investigation (however, often times Sacramento PD will provide a courtesy response, take the initial report, and forward the report to the appropriate agency for further investigation).
- Does the Office of Investigations feel cross-reporting with CPS is happening as it should?
    - Yes, the Office of Investigations has a good working relationship with CPS. It also helps to have the CPS Social Worker out-stationed in our office.
- What training do patrol officers receive regarding child abuse/sexual assault?
    - There is a block of classes dedicated to this topic through the Police Academy and is required of all officers to complete every two years.
    - This topic is covered through the Field Training Program, which includes a written manual to reference policy and procedures.
    - Ride-along training as also used, pairing new officers with experienced officers to respond to calls.
- Are more resources needed for the Sacrament PD's Office of Investigations to provide services?
    - More resources are needed across the board.
- The Critical Incidents Subcommittee sees many cases with a history of domestic violence. What are the Office of Investigations' thoughts about resources?
    - WEAVE and My Sister's House are valuable community resources. They help victims become empowered to free themselves from abusive relationships.
- At what point does CPS call Law Enforcement (LE) for assistance?
    - CPS calls LE for a variety of things such as support services, when a Social Worker sees evidence of violence, assistance with removals, protective custody warrants served, and more. CPS and LE frequently collaborate out in the field.
- When there is a call to respond to an incident of domestic violence, is an arrest typically made?
    - Yes, the law mandates that an arrest is made for incidents of domestic violence. The primary aggressor is arrested.
- How does Sacramento PD you respond when there are children in the home when you are making an arrest for a domestic violence incident?

- The officer assesses the situation for immediate danger. If the other parent is not present and the arrested parent wishes to release the child to someone else, the officer will run a background check on the person, and often times call CPS to see if there are any reports made against the person, before releasing the child to them. The incident is reported to CPS and CPS takes over with follow-up investigative work.

November 2016

Collaboration with Local Law Enforcement, Sacramento County Sheriff's Department

Sergeant Tony Saika of Sacramento County Sheriff's Department's Centralized Investigations Division provided an overview of how the Department's Child Abuse Bureau responds to and investigates child abuse.

- The Centralized Investigations Division provides detective services in the following crime categories: Child Abuse, Cold Case Investigations, Crimes Against People, Felony Assault, Gang Suppression, Homicide, Major Crimes, Missing Persons, Property Crimes, Robbery, Sexual Assault/Elder Abuse, and Sexual Assault Felony Enforcement.
- The Child Abuse Bureau investigates crimes against children under the age of 18, and sex abuse crimes of children under the age of 14 (14+ are investigated by the Adult Sexual Assault Unit). A child abuse case may involve infant death, physical abuse, child molest, neglect and indecent exposure.
- Response protocols are similar to that described by the Sacramento PD's Office of Investigations.
- Thousands of Forms 11166 (Suspected Child Abuse Report) are received, triaged, logged in a database, and filed annually. Most of the reports are generated by mandatory reporting agencies. The database allows investigators to look up previous history of reports on suspects.
    - New reports are prioritized based on level of severity and take no longer than five days to process once they are submitted to the Child Abuse Bureau.
- From January 1, 2016 to the date of this presentation (December 13, 2016), 816 reports were taken and 250 were assigned to a detective to investigate.
    - The reports that were unassigned were either referred to other jurisdictions or there was not enough physical evidence to be able to prosecute.
- The job of the Investigator/Detective is to build a prosecutable case that can be proven beyond a reasonable doubt, and they work closely with the District Attorney's Office on cases.
- The Child Abuse Bureau takes a multi-disciplinary approach, working with many other child protective agencies. Detectives have close working relationships with the District Attorney's Office, Child Protective Services, other law enforcement agencies, physicians, and other emergency personnel.
    - A CPS liaison is outstationed in the Child Abuse Bureau's office. This helps by expediting processes, educating staff about policies and procedures, and ensures effective and efficient collaboration.
    - Unit staff members participate on the Child Death Review Team, as well as SCAN meetings – a multi-disciplinary approach where child abuse cases are discussed to ensure the children are receiving the appropriate resources.
- The Sheriff's Activities League team provides prevention and early intervention services by reaching out to and developing bonds with youth in the community through sports and instructive activities and by establishing mentoring relationships.

Issues of concern were discussed. Questions were addressed.

- Do all Patrol Officers have cameras?
    - Yes, officers use iPhone – however they refer to crime scene investigators for the high quality pictures of evidence.
- Does the Sheriff's Department respond assertively to reports of Domestic Violence?
    - Yes, cases are handled assertively and the aggressor is taken into custody. If the victim is willing to press charges, the Sheriff's Department will help them prosecute.
    - The Domestic Violence unit is housed in the same building as the Child Abuse Division. The two units collaborate on cases.
    - There will be a staff person from WEAVE (Women Escaping A Violent Environment) outstationed in the unit's office soon.
- What training do patrol officers receive regarding child abuse/sexual assault?
    - Patrol Officers receive curriculum-based, scenario training through the Sheriff's Academy on sex crimes and physical abuse with children, as well as domestic violence training.
    - Ride-along training as also used, pairing new officers with experienced officers to respond to calls.
- Are more resources needed for your agency to provide services?
    - The Child Abuse Bureau used to have ten detectives on staff, but was reduced to seven during the County's budget cuts in 2009. No new positions have been restored since then. An additional detective would help alleviate some of the workload.
    - The Child Abuse Bureau and the Sexual Assault Bureau have come up with an innovative way to address staffing challenges. Since it is protocol for two officers to respond to after-hours call-outs, the two bureaus are pooling their staffing resources and assigning one Child Abuse and one Sex Assault detective to respond. Not only does this give some reprieve to staff by widening the pool, but also it allows for service/response by detectives of multiple disciplines.
- How many detectives are female?
    - Four of the seven detectives are female. Having diversity in gender works great for the unit and those they serve.

Appendix D: Acronyms and Abbreviations

ACFP – A Community for Peace

AOD – Alcohol and Other Drug

AWOL – Absent Without Leave

BEAR – Bridging Evidence Assessment & Resources

BHS – Behavioral Health Services

BOS – Board of Supervisors (Sacramento County)

CAN – Child Abuse and Neglect

CASA – Court Appointed Special Advocates

CCIC – Critical Case Investigation Committee

CCR – Continuum of Care Reform

CCS – California Children's Services

CDRT – Child Death Review Team

CDSS – California Department of Social Services

CFSR – Child and Family Services Review

CFT – Child and Family Review Team

CHDP – Child Health and Disability Prevention

CHPD – Citrus Heights Police Department

CI – Critical Incidents

CIL – Community Incubator Lead

CPS – Child Protective Services (Division)

QIC – Quality Improvement Committee

CSEC – Commercially Sexually Exploited Children

CWS/CMS – Child Welfare Services/Case Management System

CYPM – Crossover Youth Practice Model

DHA – Department of Human Assistance

DHHS – Department of Health and Human Services

DTECH – Department of Technology (Sacramento County)

DV – Domestic Violence

EFC – Extended Foster Care (California AB 12)

EO – Evaluated Out

EPY – Expectant and Parenting Youth

ER – Emergency Response

FFA – Foster Family Agency

FTE – Full Time Equivalent

H4K – Hearts for Kids

ILP – Independent Living Program

IS – Informal Supervision

LE – Law Enforcement

MDT – Multidisciplinary Teams

NMD – Non-minor Dependent

PCP – Primary Care Physician

PD – Police Department

PH – Public Health

PHN – Public Health Nurse

P&P – Policy and Procedure

QIC – Quality Improvement Committee

RAACD – Reduction of African American Child Deaths

RDA – Resource Development Associates

SB – Senate Bill

SCAN – Sacramento Child Abuse and Neglect (Team)

SETA – Sacramento Employment and Training Agency

SSF – Sacramento Steps Forward

SHRA – Sacramento Housing Redevelopment Agency

SOP – Safety Organized Practice

STRTC – Short Term Residential Treatment Centers

SW – Social Worker

TAY – Transition Age Youth

TDM – Team Decision Making

VOA – Volunteers of America