EXPLORING THE PURPOSE AND VALUE OF CHILD PROTECTION TEAMS

The death of Rafael Gomez is the second child fatality in the past three years to raise serious concerns about the DSHS Division of Children and Family Services' (DCFS) use of Child Protection Teams (CPTs). Despite a consensus among state policymakers and previous fatality review committees regarding the value of CPTs in assisting DCFS with risky and/or complex decisions, the agency thus far has failed to ensure their proper implementation and use.

This section outlines the history of CPTs and describes the Ombudsman's recent review of CPT practices. It also sets forth the Ombudsman's findings and recommendations.

The Ombudsman Review of Child Protection Teams Resulted in Recommendations:

- Clarify policy and practice guidelines.
- Create a system of accountability.
- Require training for DCFS staff and CPT members.
- Provide support, authority, sufficient time for coordinators.

Background

Child Protection Teams consist of volunteer community professionals with a wide range of expertise who assess child protection/welfare cases and provide advice and consultation to DCFS on critical decisions. There are currently 76 CPTs throughout the state.

The Legislature first established CPTs in 1987, following the death of three-year-old Eli Creekmore after DCFS returned him to his parents' care. In an effort to improve critical case decision making, the Legislature required DCFS to make CPTs available for consultation on cases involving serious child safety issues and disputes over whether to remove a child from home.[1] In 1995, following the death of three-year-old Lauria Grace after she was returned to her mother by DCFS without a CPT consultation, Governor Mike Lowry, acting upon a recommendation by a community fatality review team, issued an Executive Order mandating CPT consultation by DCFS workers in particular child protection cases.[2]

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[1] RCW 74.14B.030 provides: "[t]he department shall establish and maintain one or more multidisciplinary teams in each state region of the division of children and family services. The team shall consist of at least four persons, selected by the department, from professions which provide services to abused and neglected children and/or the parents of such children. The teams shall be available for consultation on all cases where a risk exists of serious harm to the child and where there is dispute over whether out-of-home placement is appropriate."

[2] Executive Order 95-04 states: "The Department of Social and Health Services shall utilize the multidisciplinary community protection teams established pursuant to RCW 74.14B.030 as follows: A. In all child protection cases in which the risk assessment results in a "moderately high" or "high" risk classification, and the child is age six years or younger; B. In all child protection cases where serious professional disagreement exists about a risk of death or serious injury; C. In all child protection cases that are opened on the basis of "imminent harm"; and D. In all complex child protection cases where such consultation will help improve outcomes for children. The Department of Social and Health Services shall establish, maintain, and staff multidisciplinary community protection teams sufficient to review these cases as soon as feasible and shall continue to develop a broad array of team members who will work with the department to make the best decisions possible to protect and improve the lives of the children in our state."

In 2000, in the course of reviewing the tragic death of three-year-old Zy'Nyia Nobles, the Ombudsman and a community fatality review team identified serious concerns regarding the agency's utilization of the CPT. Specifically, it was noted that information provided by the DCFS worker to the CPT was inaccurate and incomplete, and "presented in a manner to support [the worker's] belief that the child[…] should be returned to [her] mother."[3] The worker's selective presentation of information led the CPT to support her flawed plan to return Zy'Nyia to her mother, who was subsequently convicted of murdering the girl.

Following Zy'Nyia's death, DSHS Secretary Dennis Braddock released the *Kids Come First Action Agenda*, which included a provision to improve the use of CPTs by "clarifying expectations," "tracking performance," and "providing training and new tools to improve their effectiveness." The Ombudsman applauded the *Agenda's* CPT component, noting that the use and effectiveness of CPTs varied widely across the state. The Ombudsman observed that while CPTs are often used as intended – to assist workers with risky or complex decisions – CPT members report that they are also often used by workers to "rubber stamp" critical decisions that workers have reached on their own.

A little over three years later, following the death of two-year-old Rafael Gomez after DCFS returned him to his parents' care, serious concerns about the agency's use of CPTs arose once again.[4] In this case, the community fatality review committee stated that it was troubled by the "serious flaws" in the CPT system that appeared to have led the CPT to support the worker's plan to return Rafael home. The fatality committee recommended a statewide review of the CPT process, specifically including the following items:

- Clarification of the role of CPT members
- Appointment of designated "devil's advocate"
- CPT membership composition
- Variability of participation by CPT members
- Invitation and inclusion of service providers, foster parents, guardians ad litem
- Case staffing and continuity of teams
- Case presentation and sharing of source documents with CPTs
- Time allocation and format of case staffings
- Resolution of dissent and disagreement by CPT members on recommendations to DCFS

Following Rafael's death, as part of *Kids Come First: Phase II,* Uma Ahluwaila, Assistant Secretary for the DSHS Children's Administration, proposed to "review and revise the CPT model to improve consistency and effectiveness."[5]

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[3] Zy'Nia Nobles Community Fatality Review Report, November 2000; see also, Ombudsman July 2000 Review of Zy'Nia Nobles Fatality (edited to protect confidentiality): www.governor.wa.gov/ofco. The Ombudsman noted: "[T]he […] independent evaluation and oversight functions of the CPT […] appeared to have been undermined as a result of having received information from the caseworker that was not entirely accurate or complete . . . ."

[4] Rafael Gomez Community Fatality Review Report, May 2004; see also, section titled "A Fatality Review: Rafael Gomez" of this report.

[5] Children's Administration Program Improvement Plan/Kids Come First: Phase II, section 4.4 (draft).

Ombudsman Review

The Ombudsman's review of CPT practices was prompted by concerns brought to the Ombudsman's attention by parents, relatives, community professionals, and occasionally, by CPT members themselves.

These concerns include:

- Failure to schedule CPT reviews in appropriate cases or in a timely manner
- Failure of DCFS workers to provide current, complete case information to team members
- CPT decision-making process
- DCFS' failure to follow CPT recommendations[6]
- Whether and how parents, foster parents and other relatives are included (or excluded) and treated in the CPT review

Because CPTs represent such a vital component of the system's cross check on caseworker bias, and due to the recurring concerns expressed in the past two community fatality review reports and in complaints to the Ombudsman, the Ombudsman determined that an independent review of CPT practices was warranted.

Review Process

The Ombudsman's review included a review of: CPT-related complaints to the Ombudsman; pertinent statutes, executive orders, policies and procedures; relevant portions of the agency's strategic plans; monthly state Outcome Measures on CPTs; the CPT Volunteer Handbook; the Kids Come First CPT Curriculum; and materials developed by the statewide CPT coordinators group. In addition, the Ombudsman interviewed: a lead CPT coordinator from each region and 12 other current and former CPT coordinators (including facilitators who are not DCFS staff); a sampling of 20 current or former CPT members with a variety of professional perspectives and a range of experience; several family members who participated in a CPT staffing; agency staff involved in administration of CPTs; and other community professionals who have extensive experience providing services to families whose cases have been referred to a CPT for review.

Findings and Recommendations

Despite the agency's effort to implement CPT improvements outlined in Secretary Braddock's *Kids Come First Action Agenda*, the Ombudsman found there has been marginal overall change in their structure or use statewide. There continues to be disagreement within DCFS as to the essential purpose and value of CPTs and virtually no uniformity in CPT practices among DCFS regions, or even among local offices within regions.

A group of CPT coordinators from across the state has been meeting regularly to promote uniform policies and practices.[7] The group has attempted to clarify policy and developed a CPT volunteer

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[6] Section 2562 of the DSHS Children's Administration Practices and Procedures Guide states that CPT recommendations are advisory, but **must** be followed when deciding to place a child or return a child home.

[7] There are currently 45 CPT coordinators across the state. Coordinators may be either DCFS staff or contracted personnel.

training manual and a standardized CPT review form that also serves as a guide for CPT meetings. Notwithstanding these efforts, there continues to be a significant lack of clarity within DCFS and among the larger community as to the purpose and value of CPTs: why they exist, whether they're useful, and the types of cases that should receive a CPT review. This lack of clarity has resulted in inconsistent policy interpretations and practices across the state.

The following comments are illustrative of the current confusion:

> *"CPTs were created by Executive Order—that's never going to go away—so the department [DCFS] has to make the best of it." [Regional CPT coordinator]*
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> *"The caseworker told our team that she was just bringing the case for review because she had to, even though the child had already been removed." [CPT member]*
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> *"There is such a shallow level of information presented by the department, the coordinator is watching the clock and not listening; therefore outcomes are predetermined." [CPT member]*
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> *"CPTs are a set-up for failure, usually used by the department to manipulate the placement decision. How can people who don't know the case be helpful in twenty minutes' time?" [CPT member]*
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> *"The department is incapable or unwilling to make difficult placement decisions and are abrogating their lawful responsibility by passing it off to a CPT." [community professional]*
>
> *"We haven't been given the resources to handle the extra work created by CPT mandates." [DCFS CPT coordinator]*
>
> *"CPTs should be self-governing…when run by the department they are used to corral, limit, homogenize the decision-making." [volunteer CPT facilitator]*
>
> *"The department [DCFS] is responsible for placement decisions and therefore should not refer to CPTs as 'shared decision making" but rather "informed decision making." [community professional]*

Recommendations

- The Children's Administration (CA) leadership should work closely with DCFS staff, community professionals, and service providers across the state to develop a clear and shared understanding of the purpose and value of CPTs. The leadership should also clearly communicate, and regularly reiterate, its expectations regarding the agency's use of CPTs.
- The Children's Administration should place its full endorsement and sufficient resources towards supporting a CPT system that functions uniformly statewide, by addressing the following areas:

Clarify policy and practice guidelines for CPTs

Although CA policy has laid out guidelines for CPT practice, there is still ambiguity and room for widely varying interpretations. One respondent characterized the Executive Order requiring CPTs as "pie in the sky." Regional CPT policies vary from having none at all to being very specifically delineated. In response to the Ombudsman's request for regional policies, one region responded that it "follows the Executive Order"; another said it was "in the process of writing a regional policy"; three

regions submitted policies with varying detail although none had been updated since 1999. Only one region's policy provided detailed guidance for agency workers as to which cases are to be staffed, as well as scheduling, conducting, presenting at CPTs, and documenting and following through with recommendations.

The state CPT coordinators group has attempted to clarify ambiguous areas. A stronger leadership role by CA leaders in clarifying and enforcing CPT policies would effect more rapid and uniform change.

CA policy should further define:

Which cases must be referred to a CPT and at what point in case planning. A study of the CA policy leaves the reader with many questions as to specific case scenarios. The CPT coordinators group, described earlier, has spent considerable time discussing clarifications to address the ambiguities but does not have the authority to implement or enforce these clarifications.

Membership composition. Teams often fail to have a drug and alcohol expert as a regular participant. It is also difficult for many teams to secure a law enforcement specialist as a team member. These two areas of expertise, along with mental health, have been cited by child fatality reviews as significant omissions. Current CPT policy does not comment on whether or how to include these important perspectives.

Bias/conflict of interest. The Ombudsman found several instances of team membership including professionals who had generated the initial CPS report or who were simultaneously providing evaluative or therapeutic services to the subject child or family.

DCFS participation. CA policy provides no guidance on how many DCFS staff may attend a CPT or what is their appropriate role. One CPT member complained that there are usually three or four DCFS staff at the meeting, "trying to control the process and telling us what we can't decide." The Ombudsman found that DCFS staff usually do not vote on recommendations, but they do sometimes attempt to influence the team's recommendation by citing legal constraints or lack of agency resources to provide desired services.

Who may attend and present. Current CA policy states that the family shall be invited "if appropriate,"[8] but some teams never invite parents or foster parents as it is "not part of the culture". Other CPTs always invite parents, and in some instances, it is left to the discretion of the DCFS worker. Similar questions exist as to guardians ad litem and attorneys. One experienced CPT coordinator explained that parents and legal advocates are not invited to meetings because CPT reviews are "internal" and for the purpose of assisting the DCFS worker. That office does not want to duplicate the work on the case by re-interviewing family or having a quasi-legal staffing.

Recommendations. There were numerous complaints regarding the lack of sufficient time for the CPT to review materials and have meaningful discussions about recommendations. There are also problems when CPTs cannot come to agreement at an initial staffing and request

[8] Children's Administration Practices and Procedures Guide, Sec. 2562(B)(1)(b)(ii).

more information; and then they may not have the same members in attendance at a follow-up CPT.

Documentation. Some teams take minutes, documenting the discussion and recommendations, others do not. It is clear that not all teams are using the standardized forms developed by the CPT coordinators group.

Create a system of accountability for following CPT policy

Currently there is no system to ensure that DCFS holds a CPT review in all cases in which the policy mandates, such as an information system to track compliance and report on CPT results. The Ombudsman found that it is left to DCFS workers and supervisors to request a CPT when required. There seems to be more vigilant use of CPT reviews in a timely manner by Child Protective Service (CPS) workers, and Child Welfare Service (CWS) workers are less likely to prioritize CPTs in their case planning. One CPT coordinator reported that a recent quarterly regional "Central Case Review" found that 85 percent of CPS cases were in full compliance with CPT mandatory review requirements, while only 25 percent of CWS cases complied with this standard.

At a minimum, DCFS should document in the CAMIS-GUI [9]information management system whether a CPT review is required. Additionally, after each CPT meeting a summary of the review and the CPT's recommendations should be entered into CAMIS. Currently, CPT recommendations are usually not recorded in CAMIS. These entries could assist in case management and accountability and also provide data for quality assurance purposes.

Require training of DCFS staff

Ongoing training needs to communicate the purpose and usefulness of CPTs. Workers need support in making the best use of CPT recommendations in their case planning. The most frequently cited complaint was related to workers not providing full and accurate information to the CPT. In order for a CPT review to serve its intended purpose, the worker must be willing and able to provide complete information about the case and be open to receiving challenging questions from team members. There have been complaints that some workers find the CPT process creates unnecessary work, threatens their practice decisions, and is superfluous to case planning. Some workers receive no training about how to use and present at CPT meetings. There have also been complaints of workers coming unprepared to CPT reviews and—more seriously—deliberately withholding or slanting information in order to manipulate the team's recommendations. One community agency director no longer allows staff to vote at CPT meetings due to a lack of confidence that the team is being provided accurate information on which to base their recommendations.

Provide support, authority, sufficient time and specialized training for CPT coordinators/facilitators

CPT coordinators must be able to effectively recruit, train and facilitate the teams. In some offices, teams are coordinated and facilitated by a DCFS worker who has this as one of many job responsibilities. One region has contracted CPT facilitation to a for-profit group of professionals who work with a DCFS coordinator. Some teams are facilitated by volunteer community professionals. The roles and duties of coordinators and facilitators should be clearly defined. Many coordinators have

[9] CAMIS is the Children's Administration information system in which they document activity on each case, such as the social worker's contact with the children, family, and service providers..

not received the leadership training necessary to mediate difficult discussions among strong personalities. In small communities where there is little anonymity, the coordinator has an additional challenge of conducting a truly unbiased, critical decision-making process. CPT coordination and facilitation requires strong leadership and organizational skills, as well as dedicated time.

Require orientation and training for all volunteer CPT members

Currently, community volunteers are not required to receive training before serving on a CPT. The agency has produced a comprehensive manual - Child Protection Team: Volunteer Handbook (February 2003). However, its use varies widely. For example, the Ombudsman found that a few CPT coordinators were not aware of the Handbook, while other CPT members have received the Handbook but no follow up orientation or training. DCFS has also developed a CPT training curriculum, and there has been a push in some regions in the past year to provide training to CPT members. However, not all coordinators have been trained to use the curriculum, and those that have say they do not have adequate time to make use of this resource. This is highly unfortunate because, in addition to providing comprehensive information about Children's Administration mandates and CPT processes, the curriculum covers how to "apply the principles of critical thinking to the review process." Lack of critical thinking was cited as a CPT failure in the Gomez fatality review. Critical thinking is an essential part of optimal CPT decision-making and should be expected.

Although there is no data documenting how services have been enhanced and how many child injuries or deaths have been prevented due to CPT recommendations, the Ombudsman did find cases where CPTs operated in a manner helpful to the DCFS' decision-making. When Children's Administration conducts their review of the CPT system, the Ombudsman recommends that they make use of these best practices and products already developed, e.g. the Volunteer Handbook, the training curriculum, the work of the CPT coordinators group; build on these; and ensure they are used by all CPTs throughout the state. The Ombudsman will continue to monitor use of CPT reviews in ensuring child safety and family preservation.