



*oppaga*

# Performance Review

February 2001

Report No. 01-06

## Client Characteristics and Outcomes Are Similar for Both Administrative and Judicial Review of Child Abuse Cases

### *at a glance*

This is the second of two reports on the Department of Children and Families' administrative review process for child abuse investigations. In this report, we compare the characteristics and outcomes of children whose child protection investigations were subsequently examined by the department's administrative review process and those whose cases were reviewed through the court system. Our analysis of child abuse reports that were investigated and closed during the period from January 3, 2000, through September 30, 2000, determined that

- children in both groups have similar demographic profiles and similar types of verified maltreatment, and
- about one-fourth of the children in both groups had subsequent alleged abuse reports.

### Purpose

Chapter 99-168, *Laws of Florida*, directed the Office of Program Policy Analysis and Government Accountability (OPPAGA) to analyze and report on all child protective investigation cases that were subject to a statutorily mandated administrative review by the Department of Children and Families. In December 1999, OPPAGA issued a report

([OPPAGA Report No. 99-20](#)) that addressed the status of implementation of the administrative review process.<sup>1</sup> This final report analyzes statewide data provided by the Department of Children and Families' Florida Abuse Hotline Information System (FAHIS) to compare

- the characteristics of children that the department takes into custody or files a court dependency petition for, versus children in cases where the department does not take these actions and reviews case decisions solely through administrative review and
- whether the department receives subsequent reports of suspected abuse, neglect or abandonment on these two groups of children.

### Background

Due to concerns that the department was not appropriately considering the potential risk to children in child protective investigations that did not result in court action or removal of the child from the child's home, the 1999 Legislature amended Ch. 39, *Florida Statutes*, to require the department to establish an administrative review process for these investigations (Ch. 99-168, *Laws*

<sup>1</sup> <http://www.oppaga.state.fl.us/reports/health/r99-20s.html>

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of Florida). The department is to conduct an administrative review for each case in which it decides to leave a child in their home and not take the child into custody or file a dependency petition with the courts.<sup>2</sup> At a minimum, the department is to conduct an administrative review when a family has not complied with a previous case plan or when the child was identified in a previous report as a victim of abuse and/or neglect. The administrative review process is intended to ensure that the department takes appropriate and adequate measures to prevent further harm to abused and neglected children.

### *Child protective investigation process*

The department's child protective investigation program operates by receiving, investigating, assessing, and processing reports of abuse, neglect, and abandonment of children. Chapter 39, *Florida Statutes*, requires that any person who knows or suspects that a child is being abused, neglected, or abandoned report the information to the department's central abuse hotline. Appendix A provides an overview of the department's child protective investigation process as modified by the provisions of Ch. 99-168, *Laws of Florida*.

The department's child protective investigation units located in offices throughout the state are responsible for investigating reports. All reports have to be investigated within 24 hours of receipt; cases in which a child is in imminent danger of further harm must be investigated immediately. In Fiscal Year 1999-2000, the department investigated 164,464 reports and found that 76,494 children were the victims of abuse or neglect.

If an investigator finds that the alleged abuse or neglect did occur, a case plan is often developed with the family. A case plan is a written, time-limited agreement that is negotiated between the department and the victim's family. It specifies

the responsibilities and actions of the department, the family, and other parties. The case plan is intended to ensure the health and safety of the child and resolve the problems that necessitated department intervention.

In cases where the safety of a child cannot be assured or high-risk factors are present, the department may need to initiate judicial intervention by removing the child from the home and/or filing a court petition for dependency. The protective investigation supervisor will refer a case to dependency court if voluntary services are not appropriate or sufficient to ensure the safety of the child. The department may seek court involvement even if the department decides to not remove a child from the home. Court involvement may be necessary when either the parent or guardian did not comply with a previous voluntary case plan, or has refused the voluntary services offered by the department.

### *The department had implemented an administrative review process as of May 1999*

To fulfill the requirements of Ch. 99-168, *Laws of Florida*, to establish an administrative review process, the department is using the supervisory review component of its Initial Child Safety Assessment.<sup>3</sup> Under this process, the protective investigator must assess the immediate safety risk(s) for each child in a family that is subject to a child protective investigation within 48 hours of making face-to-face contact with the alleged child victim and family members. The investigator's supervisor must then review the appropriateness of this assessment as well as any safety actions that were taken or proposed by the investigator within 72 hours of receiving the investigator's initial assessment.

If the supervisor determines that the investigator's recommendations concerning the child are not appropriate, the supervisor may require an alternative course of action that may include removing the child from the child's home or filing a court dependency petition. The supervisor has 24 hours to provide comments to

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<sup>2</sup> Chapter 39, *F.S.*, authorizes the department to file a petition with the courts to declare a child dependent under certain circumstances. In this context, s. 39.01, *F.S.*, defines "[a] child who is found to be dependent" as a child who has been abandoned, abused, or neglected or is at substantial risk of imminent abuse, abandonment, or neglect by the child's parents or legal custodians. A dependency petition may establish a court order that certain services, such as protective supervision, be provided to the family on a non-voluntary basis.

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<sup>3</sup> The department implemented the assessment tool statewide in May 1999, and an automated version was implemented in January 2000.

the investigator after completing the supervisory review.

In addition, protective investigation supervisors are required to refer certain high-risk cases for a second-party review. Second-party review occurs in all cases where the caregiver is responsible for the death or serious injury of another child. A review is also to occur if two or three of the following factors are present:

- the child is age four years or younger or is non-verbal;
- there are prior reports involving the child regardless of findings; and
- there is a current report of actual serious or severe injury, neglect, or threatened harm.

## Analysis

Chapter 99-168, *Laws of Florida*, requires OPPAGA to compare characteristics and outcomes for children who have gone through the administrative review process and those children who have gone through the court system. We analyzed 59,619 child abuse reports that were investigated and closed for the period of January 3, 2000, through September 30, 2000. These reports identified 89,401 children who were alleged victims of abuse or neglect. Our analysis focused on the 35,679 children in this population who had been subjects of previous departmental investigations. Of these alleged victims, 31,442 children (88.1%) had gone through the administrative review process, and the remaining 4,237 children (11.9%) had gone through the court system. (See Exhibit 1.)

Our comparison was hindered because the department's Initial Child Safety Assessment information system does not capture data on risk factors that may be associated with alleged abuse or neglect, such as a caregiver's suspected substance abuse or mental illness.<sup>4</sup> In addition, this information system did not contain complete

information on child protective investigations conducted by some of the department's 15 service districts or by sheriff offices. However, we were able to use data provided in the department's Florida Abuse Hotline Information System to compare the client populations for some variables, including demographics, types of maltreatment, and the occurrence of subsequent reports of abuse or neglect. The Florida Abuse Hotline Information System did not contain information that would allow us to distinguish the children whose cases had been subject to Second Party Review. The Second Party Review is the department's additional level of administrative review for cases that meet certain high-risk criteria.<sup>5</sup>

### Exhibit 1

#### More Than One-Third of the Department's Investigation Caseload Involves Children Who Had Been Subjects of Prior Investigations

	Administrative Review Only	Judicial Review <sup>1</sup>	Total
All alleged child victims	82,191	7,210	89,401
Alleged child victims that were identified as victims in prior child abuse/neglect report(s)	31,442	4,237	35,679 (39.9%)

<sup>1</sup> OPPAGA is using the term "judicial review" as a general reference to any dependency court involvement in child abuse and neglect cases.

Source: OPPAGA analysis of Department of Children and Families data.

Our analysis concluded that

- both client groups had similar demographic profiles and the most prevalent maltreatment finding for both groups involved neglect, and
- both client groups had similar rates of subsequent abuse reports (about one-fourth of the children in both groups had subsequent reports).

<sup>4</sup>The automated version of the Initial Child Safety Assessment was designed to be a temporary system whose functions would be eventually integrated into the state's automated child welfare information system, Home SafeNet. The piloted version of the automated Initial Child Safety Assessment that OPPAGA addressed in Report No. 99-20 did capture information on various safety factors, such as parental substance abuse. However, the version that was implemented statewide after the publication of Report No. 99-20 did not capture the risk factors.

<sup>5</sup> We were able to determine if a Second Party Review was completed for a non-representative sample of children. The sample was captured in the Initial Child Safety Assessment system during the period from January to July 2000.

### Both groups have similar demographic profiles

We found no significant differences between the demographic profiles (age, gender, and ethnicity) of alleged child victims receiving administrative review and those children whose cases had judicial oversight. For example, the majority of children in both groups were 10 years old or younger; 58% of the children whose cases received administrative review and 65.6% of children whose cases had judicial oversight were 10 years old or younger. (See Exhibit 2.)

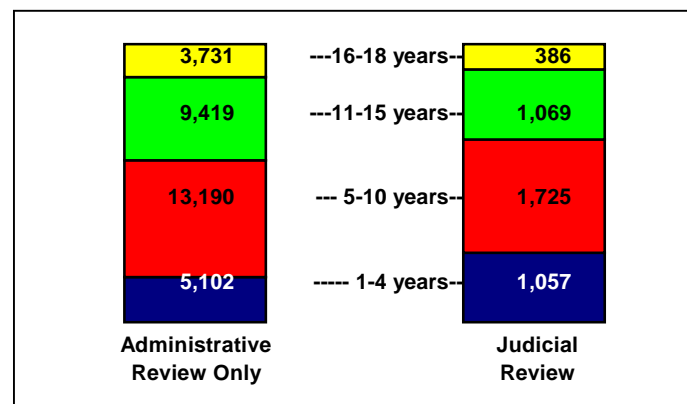
There are also similarities in the gender and racial/ethnic composition of both client groups. Both groups were almost equally divided between males and females; with 50.9% of the alleged victims being female and 49.1% male in the administrative review category compared to 51.4% female and 48.5% male in the judicial review category. In addition, both groups had similar racial breakdowns; approximately two-thirds of the alleged victims were white and one-third were black. Slightly less than 5% of the alleged victims were identified as having Hispanic ethnic backgrounds. We found a slightly higher percentage of black children in cases that received judicial review compared to cases that only received an administrative review. (See Exhibit 3.)

### Some differences in investigative findings exist for children in both groups

We also found that there were differences in the investigation findings between the two groups of children. One-fifth of the children whose cases were subject to judicial review had one or more maltreatment allegations substantiated by protective investigations. (See Exhibit 4.) This represents a higher percentage of substantiated allegations than for children whose cases had been administratively reviewed (13.3%). This makes sense because the dependency court is most often involved in those cases where children are considered to be at the highest risk of future abuse and/or neglect.

#### Exhibit 2

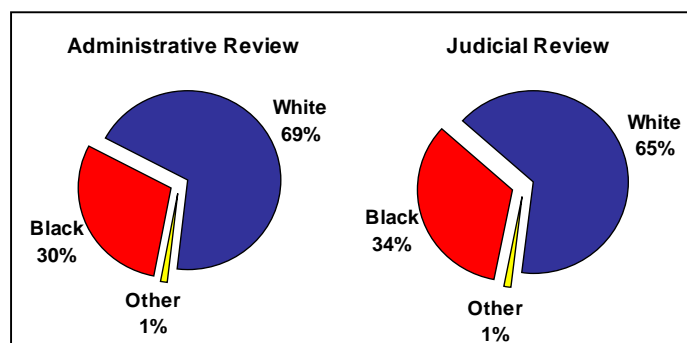
#### Most Children Are 10-Years-Old or Younger in Both Oversight Categories



Source: OPPAGA analysis of Department of Children and Families data.

#### Exhibit 3

#### There Are Similarities in Racial and Ethnic Make-Up of Children Whose Cases Were Administratively and Judicially Reviewed



Note: Other includes children whose race was listed as unknown.

Source: OPPAGA analysis of Department of Children and Families data.

#### Exhibit 4

#### Children Whose Cases Receive Judicial Review Are More Likely to Have Substantiated Findings of Abuse or Neglect

	Administrative Review Only	Judicial Review
Alleged victims whose case received each type of oversight	31,442	4,237
Alleged victims with at least one substantiated investigation finding of abuse and/or neglect <sup>1</sup>	4,175 (13.3%)	848 (20.0%)
Alleged victims with no substantiated investigation findings of abuse and/or neglect	27,267 (86.7%)	3,389 (80.0%)

<sup>1</sup> An investigation can confirm multiple maltreatments for each child victim.

Source: OPPAGA analysis of Department of Children and Families data.

As shown in Exhibit 5, the most prevalent substantiated maltreatment for both groups was neglect.<sup>6</sup> This finding is consistent with the conclusions of other state and national reports dealing with child abuse. For example, in April 2000, the federal Department of Health and Human Services reported that nationally, 54% of child victims had suffered from neglect.

#### Exhibit 5

#### Neglect Is the Most Common Substantiated Allegation for Children Whose Cases Received Either Type of Case Oversight<sup>1</sup>

	Administrative Review Only n = 4,175	Judicial Review n = 848
Neglect	1,545 (37.0%)	481 (56.7%)
Substance-related abuse <sup>2</sup>	1,019 (24.4%)	346 (40.8%)
Domestic violence	1,026 (24.6%)	248 (29.3%)
Physical injury	927 (22.0%)	233 (27.5%)
Other <sup>3</sup>	643 (15.4%)	59 (7.0%)
Sexual abuse	388 (9.3%)	91 (10.7%)
Mental injury	279 (6.7%)	81 (9.6%)
Death <sup>4</sup>	4 (0.1%)	0

<sup>1</sup> An investigation can confirm multiple maltreatments for each child victim, thus the percentage of children with substantiated maltreatments will total more than 100%.

<sup>2</sup> Substance related abuse includes poisonings and substance- or alcohol-exposed infants.

<sup>3</sup> "Other" includes situations where parents are incarcerated or hospitalized or the family has been identified by other agencies as needing assistance.

<sup>4</sup> A substantiated finding of death in an abuse investigation can be either the death of the alleged child victim in the report or another child in the household.

Source: OPPAGA analysis of Department of Children and Families data.

#### *Different case oversight did not make a significant difference in child outcomes*

We also compared the outcomes of clients in both groups to determine whether there were differences in the long-term safety of children based on the type of case oversight that was provided. We found that approximately one-fourth of the child victims in both categories had subsequent reports; slightly more child victims (26.7%) whose cases received judicial oversight had subsequent abuse reports than those victims

whose cases were administratively reviewed (23.9%). (See Exhibit 6.)

#### Exhibit 6

#### About One-Fourth of the Children in Both Groups Had Subsequent Abuse Reports

	Administrative Review Only	Judicial Review	Total
Alleged victims with subsequent abuse reports	7,518 (23.9%)	1,130 (26.7%)	8,648 (24.2%)
Alleged victims that did not have a subsequent abuse report	23,924 (76.1%)	3,107 (73.3%)	27,031 (75.8%)

Source: OPPAGA analysis of Department of Children and Families data.

To determine why alleged child victims in judicially reviewed cases had a slightly higher rate of subsequent reports than alleged victims in administratively reviewed cases, we reviewed dependency court dispositions for the alleged victims with subsequent reports whose initial cases had judicial oversight. We found that more than half (52%) of the children's cases had a court judgment that required protective supervision of their cases. This leads us to believe that there were safety factors that continued to be a concern of the department and the dependency court after the investigation was closed.

While statewide child outcomes did not differ significantly, there were significant differences between districts with regard to subsequent abuse reports. (See Appendix B.) For example, District 7 had a significantly higher percentage of child victims involved in subsequent reports. A department Strike Force report published in February 2000 identified several problems in District 7 that may help explain some of these results.<sup>7</sup> For example, the report found two problems that may directly affect child safety outcomes: high staff turnover and inadequate training and supervision of new employees. These problems may have contributed to incomplete assessments of child safety factors or inadequate child safety actions. This can result in children remaining at risk of abuse or neglect as evidenced by the department receiving subsequent reports of abuse or neglect.

<sup>6</sup> According to Ch. 39, F.S., "neglect occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental or emotional health to be significantly impaired or to be in danger of being significantly impaired. The foregoing circumstances shall not be considered neglect if caused primarily by financial inability unless actual services for relief have been offered to and rejected by such person."

<sup>7</sup> The Strike Force Report was an effort to address many of questions the department faced after several highly publicized child abuse-related deaths in that district.



## Subsequent abuse reports often lead to higher-level child safety actions

We analyzed the cases of alleged child victims that had additional reports of abuse and neglect investigated and closed for the period from January 3 to September 30, 2000, to determine what child safety actions were taken after a subsequent report was substantiated. In our analysis, a higher-level child safety action includes a child being placed with someone other than a parent, the establishment of court-ordered or voluntary protective supervision, intensive counseling and related services, or the termination of parental rights.

Subsequent abuse investigations were closed for 57% (4,930) of the 8,648 alleged child victims with subsequent reports.<sup>8</sup> Higher-level child safety actions had been taken for 9.4% (464) of these children. The majority of these children, 242 out of 464, were removed from their parents' homes. Many of the children that were removed from their parents' care were placed with relatives or in foster care. Exhibit 7 details the number of children that had each of the higher-level child safety actions taken after the department investigated and closed subsequent reports.

### Exhibit 7

#### Removal Was the Most Common Higher-Level Action Taken When the Department Received Subsequent Reports

Higher-Level Child Safety Actions Taken		N=464
<b>Dependency Court-Level Actions</b>		
Removal from parent(s)	242	(52.2%)
Court-ordered protective supervision without removal	85	(18.3%)
Termination of parental rights	5	(1.3%)
<b>Department-Level Actions</b>		
Voluntary protective supervision	78	(16.8%)
Intensive counseling and related services	54	(11.6%)

Source: OPPAGA analysis of Department of Children and Families data.

We also examined the child safety actions that were taken for a non-representative sample of 356 children that were considered to be at high

risk of abuse and neglect whose cases had received the department's Second Party Review during the period from January to July 2000. We found that 62 of these children (18.1%) had a higher-level child safety action established after the department investigated the allegations in a subsequent report. This was higher than the overall percentage of children that had a higher-level child safety action established once a subsequent report was investigated and closed.

These findings suggest that the department is appropriately using higher-level child safety actions to ensure the safety of children considered to be most vulnerable to abuse and neglect—particularly young children and children that were identified as possible victims in prior abuse reports.

## Conclusions and Recommendations

Our analysis showed similar characteristics and outcomes for children whose cases received either judicial review or only the department's administrative review.

However, we were limited in our ability to fully address how safety risk factors determine the type of oversight provided to each child's case due to data limitations. The electronic data currently collected by the department does not address many of the child safety risk factors, such as a caregiver's suspected substance abuse or mental illness. The data also did not contain complete information on all child abuse and neglect investigations conducted around the state. In addition, we found problems when we attempted to match the data across the department's automated Initial Child Safety Assessment and Florida Abuse Hotline information systems.

We recommend that the department take the necessary actions to ensure that complete and accurate information is available to facilitate future assessments of the department's administrative review practices. At a minimum, the department should ensure that

- all entities that are responsible for protective investigations are entering information into the Child Safety Assessment component of

<sup>8</sup> This analysis does not include the 3,718 (43%) of the 8,648 alleged child victims that had subsequent reports in which the investigations had not been closed at the end of our review period.

the Home Safenet information system once it is fully implemented and that

- necessary data validation practices are designed and implemented to ensure that information collected can be matched across information systems.

## Agency Response



Jeb Bush  
Governor

Kathleen A. Kearney  
Secretary

January 19, 2001

Mr. John W. Turcotte, Director  
Office of Program Policy Analysis and  
Government Accountability  
Post Office Box 1735  
Tallahassee, Florida 32302

Dear Mr. Turcotte:

Thank you for your December 27, 2000, letter providing the preliminary findings and recommendations of your performance review entitled "Client Characteristics and Outcomes are Similar for Both Administrative and Judicial Review of Child Abuse Cases."

Our response to the findings and recommendations found in your review is enclosed. If I may be of further assistance, please let me know.

Very truly yours,

/s/  
Judge Kathleen A. Kearney  
Secretary

Enclosure

### **RESPONSE TO OPPAGA PERFORMANCE REVIEW ENTITLED "CLIENT CHARACTERISTICS AND OUTCOMES ARE SIMILAR FOR BOTH ADMINISTRATIVE AND JUDICIAL REVIEW OF CHILD ABUSE CASES"**

I found the report useful and beneficial in our continuing efforts to improve our child protection system. We will compile report data that reflect the outcomes associated with the Department's decision to support tools that are designed to measure how efficiently our child welfare system functions. We share concerns related to the percentage of children in both groups that had subsequent alleged abuse reports.

The Initial Child Safety Assessment being utilized captures safety factors related to caregiver substance abuse and mental health issues. (Please refer to page 2, number 13, on the current Initial Child Safety Assessment). All districts have been instructed to use this updated safety assessment. The next version of the Child Safety Assessment scheduled for the next HomeSafenet release will also include this vital information. I recognize the need for inclusion of this safety factor information as an essential element in the data collection process.

We share the concern that District 7 has a higher rate of subsequent reports and agree with the report findings that "high staff turnover and inadequate training and supervision of new employees" has significantly impacted the District's ability to function at an appropriate level of accountability. We will continue our attempts to secure appropriate staff in District 7.

We were pleased with your findings that "the department is appropriately using higher-level child safety actions to ensure the safety of children considered to be most vulnerable to abuse and neglect." Our primary goal is to ensure the safety of all children served by the Department of Children and Families.

A data validation plan will be developed and implemented to assure that child safety assessments are being properly completed and appropriate actions are taken. HomeSafenet will provide linkage to the existing FAHIS System. This will eliminate duplicative systems that have previously collected the data. HomeSafenet is an automated system designed to assist counselors in an on-going assessment process. Additionally, this will allow all users to capture valuable information for data collection purposes.

## Appendix A

### Child Protective Investigation Process After 1999 Legislative Changes

	Investigation Activity	Required Timeframes
<b>Initial Contact</b>	Investigator locates and interviews alleged child victim and family members	Within 24 hours of receiving report from Florida Abuse Hotline
<b>Initial Child Safety Assessment</b>	Investigator completes Initial Child Safety Assessment	Within 48 hours of receiving report from Florida Abuse Hotline
<b>Administrative Review</b>	Protective investigation supervisor reviews completed Initial Child Safety Assessment	Within 72 hours of receiving Initial Child Safety Assessment
<b>Second Party Review</b>	Supervisor refers case for Second Party Review, if required	Within 24 hours of receiving Initial Child Safety Assessment
<b>Judicial Review</b>	Investigator and supervisor review findings and refer appropriate cases to juvenile court with recommendations to either remove the child from the home or to get court-ordered case plan	
<b>Investigation Case Closed</b>	Supervisor reviews case findings, child safety actions taken, case officially closed	Within 60 days of receiving report from the Florida Abuse Hotline

Source: Department of Children and Families.

## Appendix B

### Of the Department's 15 Service Districts, District 7 Had the Highest Percentage of Alleged Child Victims With Subsequent Reports for Both Groups

	Administrative Review			Judicial Review		
	Total Alleged Victims with Prior Reports	Alleged Victims with Subsequent Reports		Total Alleged Victims with Prior Reports	Alleged Victims with Subsequent Reports	
1 Escambia, Okaloosa, Santa Rosa, and Walton	2,644	620	23%	409	94	23%
2 Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington	2,905	735	25%	227	58	26%
3 Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Putnam, Suwannee, and Union	1,487	318	21%	230	46	20%
4 Baker, Clay, Duval, Nassau, and St. Johns	3,093	705	23%	263	68	26%
5 Pasco and Pinellas	1,972	485	25%	281	59	21%
6 Hillsborough	4,136	970	23%	580	157	27%
7 Brevard, Orange, Osceola, and Seminole	1,481	581	39%	348	151	43%
8 Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	2,561	583	23%	236	65	28%
9 Palm Beach	2,520	577	23%	280	83	30%
10 Broward	1,425	310	22%	161	34	21%
11 Dade and Monroe	2,123	407	19%	271	53	20%
12 Flagler and Volusia	799	250	31%	103	29	28%
13 Citrus, Hernando, Lake, Marion and Sumter	1,584	310	20%	349	81	23%
14 Hardee, Highlands and Polk	1,942	487	25%	378	133	35%
15 Indian River, Martin, Okeechobee, and St. Lucie	770	180	23%	121	19	16%
<b>State Totals</b>	<b>31,442</b>	<b>7,518</b>	<b>24%</b>	<b>4,237</b>	<b>1,130</b>	<b>27%</b>

Source: OPPAGA analysis of Department of Children and Families data.

OPPAGA provides objective, independent, professional analyses of state policies and services to assist the Florida Legislature in decision making, to ensure government accountability, and to recommend the best use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). **Florida Monitor:** <http://www.oppaga.state.fl.us/>

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John W. Turcotte, OPPAGA Director