

TEXAS



The Texas Department of Family and Protective Services (DFPS) serves as the state's child welfare agency. With regard to how it administers and delivers child welfare services, Texas has a centralized system classified as state administered. For more information, visit www.dfps.state.tx.us/Default.asp.

WHAT SPECIAL EFFORTS ARE BEING MADE IN TEXAS TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES?



Legislation passed in 2015 required DFPS to develop a comprehensive strategic plan for child abuse and neglect fatality prevention and early intervention programs. Senate Bill 206 required DFPS to develop the first plan no later than September 1, 2016, and to adopt subsequent plans every five years. The current five-year plan aligns with the recommendations of the federal Commission to Eliminate Child Abuse and Neglect Fatalities and calls for a public health approach that recognizes the importance of strong and collective responsibility across agencies (<https://legiscan.com/TX/research/SB206/2015>). [5.2b]



Cook Children's Center for Prevention of Child Maltreatment in Fort Worth and Texas Christian University's Department of Criminal Justice teamed up to use risk terrain modeling to more accurately pinpoint areas of likely child abuse or maltreatment. Risk terrain modeling takes into account the leading factors for child abuse and the significance of those factors. Using data from 2013, researchers were able to accurately predict 98% of cases for 2014 (<https://www.cookchildrens.org/maltreatment/Pages/default.aspx>). [4.1, 6.1c]



DFPS's Prevention and Early Intervention (PEI) Division has conducted several public awareness campaigns targeting specific causes of child abuse and neglect fatalities. Through these campaigns, DFPS is able to provide information to the general population, not just those who have been involved with the CPS system. Campaigns include Help and Hope (how to connect with community-based resources), Room to Breathe (safe sleep practices for infants), Watch Kids Around Water (drowning prevention), and Look Before You Lock (preventing deaths in hot cars). [7.1]



PEI houses the Office of Child Safety, which independently analyzes child abuse and neglect fatalities, near fatalities and serious injuries to better understand risk factors and systemic issues. This involves reviewing state and national trends regarding child fatalities, near fatalities, and serious injuries in DFPS cases and in the general population, as well as strategies that can be deployed by DFPS, other state agencies and local communities. The Office is specifically tasked with producing consistent, transparent, and timely review of child fatalities and serious injuries by independent experts outside any specific program; assessing root causes of child fatalities to provide guidance on the most effective prevention strategies and improvements in child welfare practices; operating with the understanding that many systems impact outcomes for children, and that prevention and intervention efforts will involve many sectors and nontraditional partners; working closely with the Department of State Health Services (DSHS) and others to share data and information; and developing strategic recommendations to bring together local agencies, private sector, nonprofits, and government programs to reduce

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child abuse and neglect fatalities. As part of this effort, DFPS and DSHS released the joint report “Strategic Plan to Reduce Child Abuse and Neglect Fatalities” in March 2015. This report identified certain risk factors and commonalities among confirmed child abuse and neglect fatalities, including individual and community risk factors for child abuse and neglect. Almost half of the confirmed child abuse and neglect fatalities involve families that have no previous involvement with DFPS, highlighting the importance of population-based strategies to reduce these deaths. By utilizing a public health approach to understand, analyze and build a comprehensive approach to target child abuse and neglect fatalities, DFPS and DSHS can leverage resources, programs and community collaborations to target specific issues and geographical areas based on their individual needs. This work will be expanded in FY 2017 to analyze child maltreatment, including fatalities, and build a public health approach between both agencies that addresses child maltreatment risk and protective factors. [5.3]



DFPS Transformation is a rigorous self-improvement process that Child Protective Services (CPS) began in 2014 to become a better place to work and the most effective program possible. It is built on the knowledge and insights of front-line staff and led by both regional and state office management. Transformation will improve child safety, build community collaboration, create a stable workforce, and build leadership. As part of DFPS Transformation, DFPS has undertaken several initiatives designed to reduce child abuse and neglect overall, with a focus on addressing child abuse and neglect-related fatalities (https://www.dfps.state.tx.us/Child_Protection/Transformation/). [7.3]



Risk assessments and structured decision-making tools are being fully revised. The safety assessment tool will assist a caseworker during the first contact with a child and family, a critical opportunity to assess safety. The new risk assessment tool will be more objective and based on actuarial principles that have been scientifically accepted and adapted for Texas. [7.3a]



CPS is expanding the use of predictive analytics to address emerging problems, coordinate and improve fragmented quality assurance processes, and establish clear accountability for overseeing change in the state office and in the regions. Currently, CPS is using predictive analytics to improve child safety in Family Based Safety Services cases by piloting real-time case reviews in high-risk cases. This pilot is set to expand statewide for Family Based Safety Services cases and then be replicated for Investigations. [2.1]



The Child Safety Review Committee (CSRC) examines issues that have implications for CPS policy and practice. It consists of internal and external stakeholders. The group reviews all information collected by each Regional Child Death Review Committee and makes recommendations to CPS based on trends and patterns. Recommendations from the CSRC have included training and additional resources for working with families with active substance abuse, domestic violence/intimate partner violence, and children with special medical needs. [6.2]



The DSHS State Child Fatality Review Team Committee (SCFRT) is a volunteer, multidisciplinary team with members from DFPS, DSHS and others throughout the state. Its mission is to reduce the number of preventable child deaths by developing an understanding of the causes and incidence of child deaths in Texas; identifying procedures within the agencies represented on the Committee that serve to prevent child deaths; and promoting public awareness and making recommendations to the Governor and the Legislature for changes in law, policy and practice. DSHS publishes an annual report from the SCFRT. [6.2]



Local Child Fatality Review Teams are multidisciplinary, multiagency volunteer teams with DFPS and DSHS membership that review child deaths on a local level from a public health perspective. By reviewing circumstances surrounding child deaths, teams identify prevention strategies that will decrease the incidence of preventable child deaths by providing assistance, direction, and coordination to

investigations of child deaths; promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities; developing an understanding of the causes and incidence of child deaths in the county or counties in which the team is located; recommending changes to agencies, through the agency's representative member, that will reduce the number of preventable child deaths; and advising the State Committee on changes to law, policy, or practice that will assist the team and the agencies represented on the team in fulfilling their duties. Texas CFRTs vary in size and the number of counties for which they review child deaths. Several teams each review deaths for one county, while others review deaths for two or more. The largest number of counties any single Texas team covers is 26 https://www.dfps.state.tx.us/Child_Protection/Investigations/Child_Fatality/. [6.2]



During the 83rd Texas Legislature, Senate Bill 66 established the Protect Our Kids Commission and tasked the Commission with studying the relationship between CPS, child welfare services, and the rate of child abuse and neglect fatalities. The Commission identified necessary resources and developed recommendations to reduce child abuse and neglect fatalities that can be implemented at the local and state level. DFPS served as one of the 15 members on the Commission. Recommendations from the Protect Our Kids Commission include prioritizing prevention services using a geographic focus for families with the greatest needs; utilizing a DFPS advisory board to make recommendations for a state strategy to promote child safety and well-being; supporting local CFRTs to ensure coordination, training, and consistency as well as better utilization of the State Child Fatality Review Team; using data to inform a public health approach to preventing child fatalities (for more information on the Protect Our Kids Commission report, see <http://texaschildrenscommission.gov/media/46100/PDF-Report-POK-Commission-December-2015.pdf>). [5.2]

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