



Critical Incident Rapid Response Team

Naika Venant

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Naika Venant
Southern Region
Circuit 11
Miami-Dade County, Florida
2017-042088

Table of Contents

Executive Summary	3
Introduction	6
Case Participants	8
Child Welfare Summary	8
System of Care Review	12
Practice Assessment	12
Organizational Assessment	13
Service Array	14
Summary	20

Executive Summary

On January 22, 2017, the department received notification that 14-year-old Naika Venant died by suicide when she hung herself in the bathroom of her foster home. The incident was reported to the Florida Abuse Hotline at which time the intake was screened in and classified as a “Foster Care Referral” given that there were no allegations of abuse or neglect on the part of Naika’s foster parents.

Given the circumstances, DCF Secretary Mike Carroll immediately initiated a special review in order to examine the circumstances surrounding Naika’s death and to assess the level of service intervention that had been in place throughout the child’s placement in state care.

In the day’s leading up to Naika’s suicide, the teen expressed sadness to both her case manager [REDACTED] over the fact that her mother told her that she didn’t want her back and that Naika was going to “age out” of the foster care system; however, she appeared “upbeat and happy” and expressed plans for the future (e.g., graduating from high school and attending college).

For nearly three hours on the evening of her death, Naika used an internet application known as Facebook Live to broadcast to the public as she contemplated ending her life in the middle of the night while hundreds of viewers were watching. For over two hours, many viewers, some of whom were her friends, were pleading with Naika to reconsider her decision, a decision of which some believe Naika, herself, was unsure. However, there were many other individuals urging her to take her own life, calling her vile names and claiming the situation was either “fake” or “all an act.”

On February 9, 2017, an abuse report was received concerning Naika’s death and alleged that Gina Caze, Naika’s mother, was following Naika while she was on Facebook Live for the two hours that preceded her suicide and, that during that time, she wrote things that could be considered mentally injurious to her suicidal child and failed to seek help for her daughter.

Using the screen name “Gina Alexis,” the following statement was allegedly written by Naika’s mother in the moments leading up to her daughter’s death:

“#ADHD games played u sad little DCF custody jit that’s why u where u at for this dumb shit n more u keep crying wolf u dead u will get buried life goes on after a jit that doesn’t listen to there parents trying to be grown seeking boys and girls attention instead of her books”.

Upon receipt of the abuse report, the special review assignment was reclassified as a Critical Incident Rapid Response Team (CIRRT) response as there was a verified prior report involving the child and her mother within 12 months of Naika’s death.

Between January 2009 and January 2017, Naika spent a total of 28 months in foster care over the course of three removal episodes: 1) January 2009 through June 2010; 2) April 2014 through June 2014; and 3) April 2016 through January 2017. While Naika had been in licensed care for nine months when her death occurred, case management services had remained engaged with Naika and her mother, [REDACTED] Gina Caze, for the 22 months that preceded her re-entry into care. Ms. Caze relinquished custody of Naika on April 20, 2016, citing that she no longer wanted the child in her home.

The review team consisted of representatives from DCF's Office of Child Welfare, operations staff from the Northwest Region, and Children's Legal Services regional director from the Suncoast Region; Child Protection Team medical director from the Northwest Region; and mental health experts from South Florida Behavioral Health Network, Citrus Health Network, Florida International University, and the University of Central Florida with various expertise in child/adolescent behavior, psychiatry, and suicidality; as well as a board certified psychiatrist with expertise in adult treatment.

The review process was two-fold:

The child welfare experts completed a review of records, including prior child abuse investigations; case management files; dependency court records; and information from the Guardian ad Litem. In addition, interviews were conducted with staff from Our Kids, Center for Child Enrichment (CFCE), Children's Legal Services, Guardian ad Litem Program, Child Protection Team, as well as staff from the regional DCF office.

The mental health experts completed a review of the various behavioral health evaluations/assessments performed by multiple providers, and reviewed the treatment records to provide an opinion with regard to their individual areas of expertise.

The following findings are offered by the review teams:

Practice Assessment

- Narrow focus during the 2009 abuse investigation and corresponding service case through the Charlee Program resulted in isolated intervention strategies (e.g., Naika's behavioral issues and her mother's use of excessive corporal punishment) and failed to fully assess the family's condition.
- Regarding the most recent entry into foster care, the level of engagement demonstrated by case management staff, as well as other providers, was a notable strength with regard to this family, and with Naika, in particular.

Organizational Assessment

- The child welfare professionals involved in this case were highly experienced and well prepared to perform their responsibilities; and while overall caseloads across the case management agency were slightly elevated, it did not have an impact in this specific circumstance.

Service Array

- Over a nine-month period between April 2016 and January 2017, Naika experienced 14 placement changes, most of which resulted from behavioral disruptions. The number of disruptions made engagement of wrap-around mental health services difficult in spite of the evident need.
- There is a shortage of Specialized Therapeutic Foster Care (STFC) homes available in the community. As a result, OurKids has begun to initiate strategies to improve service delivery by implementing internal therapeutic placement programs.

- Treatment for Naika focused primarily on the symptoms of her trauma rather than addressing the trauma itself.
- The provision of mental health-related services was fragmented, with limited information sharing among the various treatment providers and other individuals providing services to Naika.
- There was a pattern of dysfunctional/unhealthy interactions between Naika and her mother that was not effectively addressed due, in part, to the mother's level of non-compliance.

Introduction

On January 22, 2017, the department received notification that 14-year-old Naika Venant died by suicide when she hung herself in the bathroom of her foster home. The incident was reported to the Florida Abuse Hotline at which time the intake was screened in and classified as a “Foster Care Referral” given that there were no allegations of abuse or neglect on the part of Naika’s foster parents.

Given the circumstances, Secretary Mike Carroll immediately initiated a special review in order to review the circumstances surrounding Naika’s death and to assess the level of service intervention that had been in place throughout the child’s placement in state care. The multidisciplinary team was not only comprised of individuals who specialize in child welfare but also involved experts external to the child welfare organizations with expertise in child/adolescent behavior, psychiatry, and suicidality.

In the day’s leading up to Naika’s suicide, the teen expressed sadness to both her case manager [REDACTED] over the fact that her mother told her that she didn’t want her back and that Naika was going to “age out” of the foster care system.

For nearly three hours on the evening of her death, Naika used an internet application known as Facebook Live to broadcast to the public as she contemplated ending her life in the middle of the night while hundreds of viewers were watching. For over two hours, many viewers, some of whom were her friends, were pleading with Naika to reconsider her decision, a decision of which some believe Naika, herself, was unsure. However, there were many other individuals who were urging her to take her own life, calling her vile names and claiming the situation was either “fake” or “all an act.”

On February 9, 2017, an abuse report was received concerning Naika’s death and alleged that Gina Caze, Naika’s mother, was following Naika while she was on Facebook Live for the two hours that preceded her suicide and that during that time, she wrote things that could be considered mentally injurious to her suicidal child and failed to seek help for her daughter.

Using the screen name “Gina Alexis,” the following statement was allegedly written by Naika’s mother in the moments leading up to her daughter’s death:

“#ADHD games played u sad little DCF custody jit that’s why u where u at for this dumb shit n more u keep crying wolf u dead u will get buried life goes on after a jit that doesn’t listen to there parents trying to be grown seeking boys and girls attention instead of her books”.

Upon receipt of the abuse report, the special review assignment was reclassified as a Critical Incident Rapid Response Team (CIRRT) response and a team was immediately deployed.

Over the past eight years, Naika had spent a total of 28 months in foster care spanning the course of three removal episodes that occurred between January 2009 and January 2017. Naika’s first entry into foster care occurred in January 2009, after she was removed due to physical abuse inflicted by her mother, [REDACTED] Gina Caze. This was the longest of the three removal episodes and resulted in Naika being in licensed care for 17 months before she was reunified in late June 2010. Her second entry into care occurred in April 2014 and lasted only two months before the court returned her to her mother’s care over the objection of the case management agency and the Guardian ad Litem; however, on-going court-ordered case management services remained in place. Naika’s final entry into care occurred in April 2016

when her mother, Ms. Caze, relinquished custody, citing she no longer wanted the child in her home. At the time of Naika's suicide, she had been in licensed care for nine months. It should be further noted that case management services had remained engaged with the family for the 22 months that Naika was residing with her mother between June 2014 and April 2016.

Throughout the family's involvement with the child welfare system, [REDACTED] received a variety of services to include multiple assessments (e.g., psychiatric, psychological, bio-psychosocial, behavioral, mental health, etc.), as well as service regimens including individual therapy [REDACTED] family therapy, specialized counseling for sexual abuse and reactive behaviors [REDACTED] and parenting and anger management classes [REDACTED]

Case Participants

Name	Age at Time of Incident	Relationship
Naika Venant	14 years	Descendant
[REDACTED]	[REDACTED] years	Half-sibling
Gina Caze	[REDACTED] years	Mother
[REDACTED]	[REDACTED] years	Father [REDACTED]
[REDACTED]	unkown	Father of Naika

Child Welfare Summary

Years before the first report involving Naika's mother, Gina Caze, as a caregiver was received in 2006, she had already been involved with the child welfare system [REDACTED]

[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]. At age 16, she became pregnant with Naika. Shortly after Naika's birth, the mother returned to Florida, leaving Naika in Haiti in the care of her grandmother. Naika later came to live with her mother in Florida when she was approximately 18 months of age. (This information was obtained from various mental health assessments completed between 2010 and 2014 during the course of the service provision).

The first report involving Naika as a victim was received in December 2006, after she was left home alone while she was in the care of an adult male babysitter who normally watched her while the mother was working. Naika, who had just turned 4 years of age, was left unattended by the babysitter for well over an hour at the mother's residence, where there was no food or running water. At the time of investigative closure, the mother had enrolled Naika in daycare and was living in a new residence with no visible hazards noted by the child protective investigator (CPI).

When Naika was 5, a report was received in August 2008 when the mother initially refused to let Naika be admitted to the hospital for treatment of her diagnosed chronic health condition. While in the emergency room, the mother reportedly called Naika a liar and a faker and threatened to send her back to Haiti so that her own life could be better. By the time the CPI arrived on scene, Naika had already been admitted to the hospital and the mother was cooperating with medical providers. While she was receptive to a daycare referral, the mother refused to accept any counseling services for herself or Naika.

Five months later, in January 2009, a report was received when Naika [then age 6], was observed with more than 30 marks on her arms, legs, and back after her mother repeatedly beat

her with a belt. The incident occurred after the mother discovered Naika [REDACTED] engaged in a sexual act, with Naika being the aggressor. The incident occurred at the babysitter's house, another adult male with whom the mother was leaving Naika on a regular basis. Due to the severity of the physical abuse, Naika was removed from her mother and placed in licensed foster care. This was the first of three entries into foster care that Naika would experience.

Upon entering foster care, Naika continued to exhibit inappropriate sexualized behavior of an unknown origin and, as a result, was referred for services through Kristi House, a private, non-profit organization that specializes in child sexual abuse cases. In addition to her sexually reactive behavior, there were concerns that Naika may have been sexually abused on a previous occasion. This supposition was reinforced when Naika later disclosed in the course of therapy that she used to sleep in the same room as her mother's paramour(s) and that she had been exposed to pornographic videos, which she referred to as "sex movies," while residing with her mother.

Naika remained in foster care for 17 months, during which time both Naika and her mother underwent various assessments which recommended both individual and family therapy, as well as other treatment regimens. For Naika, treatment focused on her sexually inappropriate behaviors, as well as possible Attention Deficit Hyperactivity Disorder, the most common diagnosis attributed to her behavior by the various assessors. For the mother, the primary focus of treatment centered around [REDACTED]. Although the mother completed the court-ordered [REDACTED] programs, Naika disclosed that her mother would still hit her whenever she was on unsupervised visits with her.

In July 2010, one month after Naika was reunified with her mother, an institutional report was received alleging that between April 2009 and December 2009 while Naika was in foster care, she was sexually abused by [REDACTED] on at least three separate occasions. [REDACTED]

Naika was placed there and had no prior incidents of inappropriate behavior, nor any subsequent incidents following this allegation. When asked about the incident, [REDACTED] denied any sexual acts had occurred between them but stated that Naika would often bother him by sneaking into his room, attempting to touch his privates and asking him if he wanted to have "s-e-x." In response, he would tell her to get out of his room or call out for the foster mother because he knew that would make Naika run away and leave him alone. [REDACTED] corroborated this statement and noted that the subject [REDACTED] always complained that Naika was trying to come into his room and that he was often heard screaming at her to leave him alone.

While Naika and her mother maintained that Naika was a victim of forced penetration, a medical examination conducted by the Child Protection Team did not yield findings as would be expected based on Naika's statements. Additionally, both the mother and Naika became hostile during the course of the criminal investigation, especially when they were asked for specific details with regard to the previous events that brought Naika to the attention of child welfare authorities in 2009.

A review of the law enforcement report found that the mother provided information that was inconsistent and contradictory with facts that were already known. For example, when the mother was asked why she thought Naika had been sexually acting out at such a young age (in

reference to the 2009 incident), the mother couldn't provide an answer and went on to state that Naika had never been exposed to any sexually-related material or programming, or to any of the males that she (the mother) dates. This statement was in direct contradiction to what was already known to be true at that time, based on disclosures already made by both Naika and her mother to child welfare and mental health professionals. For example, Naika previously disclosed in a 2009 forensic interview that her mother had multiple boyfriends who would often spend the night and that she, herself, was often made to sleep in the bed when they were present. Additionally, both acknowledged that Naika had been previously exposed to pornographic videos prior to her coming into care in 2009.

Given the information obtained during the course of the investigation, the institutional abuse report was not substantiated and the law enforcement investigation was subsequently exceptionally cleared with no charges resulting.

Shortly thereafter, targeted case management services were engaged with the family through the Charlee Program and remained active after the court terminated supervision and jurisdiction over the case in late December.

Naika's second entry into foster care occurred in April 2014 after a report was received alleging Naika (then age 11) ran away from home because she was afraid that her mother was going to beat her again because her [REDACTED] year-old brother, [REDACTED], got hurt while she was supposed to be babysitting while her mother was at work. When law enforcement officials located Naika to return her home, she expressed fear of returning to her mother; and upon their arrival back at the residence, the mother told the officer that she didn't want Naika back and threatened to beat Naika if she was left in her care. As a result, Naika [REDACTED] removed from [REDACTED] mother and placed into foster care. When interviewed by the CPI, Naika disclosed her mother would often beat her, kick her, and slap her across the face, and reported her mother routinely left her to care for her younger brother for several hours at a time. Although the mother later disclosed that she had witnessed Naika being sexually inappropriate [REDACTED] (which Naika denied ever occurred), she continued to routinely leave [REDACTED] in Naika's care for extended periods of time.

Despite everything that had occurred between Naika and her mother, Naika longed to be home. Within two weeks of her removal, Naika was hospitalized under a Baker Act following a visit with her mother. Upon returning to her foster home from the visit, Naika asked her foster parent to kill her as she didn't want to be there anymore and wanted to go back home. This statement resulted in the prompt and appropriate initiation of Baker Act protocols so that a proper evaluation could be conducted.

Naika had only been in foster care for two months prior to the court's decision to return her to her mother's care in June 2014, over the objection of the case management agency and the Guardian ad Litem. [REDACTED]. Given that Naika had already disclosed that her mother was routinely beating her prior to her removal, it was unlikely that the mother's behaviors had resolved to a point in which reunification would be appropriate, especially with her limited level of therapeutic engagement. Prior to being reunified, Naika had been referred for Specialized Therapeutic Foster Care placement, which was subsequently abated when reunification occurred.

For nearly two years, services remained engaged with Naika and her mother, during which time multiple assessments and evaluations were again conducted. [REDACTED]

[REDACTED]

Naika's final entry into foster care occurred in April 2016, when the mother brought Naika to the case management office citing that she had "had it" with her daughter and that she was no longer willing to care for her.

Between April and June, Naika experienced three placement disruptions due to on-going behavioral issues. Naika remained in her fourth placement for four months before a disruptive episode occurred when her foster mother caught her with a cellular phone and attempted to take it away. Naika became volatile and attacked her foster mother, in addition to breaking a lamp. When the case manager asked Naika why she behaved the way she did given the positive relationship Naika and her foster mother had, Naika told the case manager that she thought she would get to go home because the last time she "acted up" (in 2014) she did.

Naika continually expressed her desire to return home as placement disruptions continued to occur. These disruptions made some of the therapeutic service provision challenging. Naika often told her therapist that she missed her mother greatly and really wanted to go back home. Although the mother was court-ordered to have weekly therapeutic visits with Naika, she failed to comply and, instead, would often have unsupervised contact with Naika through other means (e.g., social media), which often upset Naika.

At the time of Naika's death, the mother had only one task left to complete, which was to engage in [REDACTED], with which she refused to comply throughout the course of service provision. On several occasions, the case manager would encourage the mother to engage in treatment so that Naika could return home. As the months progressed, however, the mother stopped cooperating with case management and she eventually expressed she had no desire for Naika to be reunified. She made no effort to see her daughter on her birthday and even declined to see Naika for the Christmas holiday when the case manager was trying to arrange a visit between the two citing that she had been drinking and smoking and wasn't in a presentable condition. It wasn't until January 2017, however, when the mother expressed that Naika was "y'all problem" and that she was not going to do anything else regarding her case.

In the days leading up to her death, Naika acknowledged that she was sad because her mother didn't want her to come home; however, she still voiced future plans and goals for herself such as graduating from high school and going to college. Staff from both case management and the [REDACTED] office noted nothing unusual regarding Naika's behavior when they interacted with her two days prior to her death; and when notified of what had occurred, were in a state of shock.

System of Care Review

This review is designed to provide an assessment of the child welfare system's interactions with the Venant/Caze family and to identify issues that may have influenced the system's response and decision-making.

Practice Assessment

PURPOSE: This practice assessment examines whether the child welfare professionals' actions and decision making regarding the family were consistent with the department's policies and protocols.

FINDING A: Narrow focus during the 2009 abuse investigation and corresponding service case through the Charlee Program resulted in isolated intervention strategies (e.g., Naika's behavioral issues and her mother's use of excessive corporal punishment) and failed to fully assess the family's condition.

When the 2009 investigation was received, the only noted allegation was concerning the mother's physical abuse of Naika. While the physical abuse allegations were thoroughly addressed by investigative staff, other possible maltreatments (which were not included in the original allegation narrative) were never fully explored. Although investigative staff took immediate and appropriate action by notifying law enforcement, referring Naika to the Child Protection Team (CPT), initiating shelter proceedings and generating a [REDACTED] report, the maltreatment focus never broadened to incorporate the possibility that Naika had potentially been a prior victim of sexual abuse.

From a very young age, the mother had been leaving Naika in the care of adult male babysitters, one of whom left her alone for a significant period of time when she was only four years of age. Although the mother received daycare assistance in 2006 and in 2008, she was again leaving Naika in the care of an adult male prior to the 2009 investigation being received. During her interview at Kristi House, Naika disclosed that her current babysitter was actually her mother's boyfriend with whom she and her mother used to reside; and during that time, Naika reported that she used to sleep in the same room with him. In addition, Naika's sexualized behavior was immediately evident upon her placement in licensed care as she was witnessed exhibiting inappropriate actions with her toys as well as other objects, further calling into question prior victimization. The only identified maltreatment at investigative closure, however, was physical injury.

During the course of service provision, the focus remained narrow with isolated goals. Although treatment regimens included a measure of "family therapy," without understanding the household dynamics, the underlying condition could not be improved. Instead, emphasis continued to be placed on Naika's behavior management as opposed to manifestation, and the mother's response to handling Naika's behaviors as opposed to culpability.

Once Naika became engaged in services, the mother admitted that her daughter had been exposed to pornographic videos by her "former roommate;" and Naika disclosed that she also watched "sex movies" in the presence of her mother. In addition, after the court granted the mother unsupervised overnight weekend visits with her daughter, Naika disclosed that her mother made her sleep in the same bed as her [then] boyfriend (a man she did not know) and on at least one occasion, she was left in the care of another unknown adult male at the beach.

Documentation in the case record does not support that these issues were either addressed or remedied to a reasonable extent prior to Naika's reunification in June 2010.

It wasn't until the institutional report was received in July 2010 that alleged Naika had been sexually abused [REDACTED] when she was in care, when Naika's victimization began to be considered.

The Charlee Program is no longer in existence and interviews could not be conducted to address the above-noted concerns.

FINDING B: Regarding the most recent entry into foster care, the level of engagement demonstrated by case management staff, as well as other providers was a notable strength with regard to this family, and with Naika, in particular.

Over the course of service provision, Naika became known by several providers in the child welfare community including case management staff, therapists, and personnel at the [REDACTED] office. In particular, both the case manager and agency-assigned therapist had developed a close rapport with Naika over time.

The case manager had been working with the family for 15 months since being assigned the case in October 2015, when Naika was still residing with her mother. Throughout service provision, the case manager visited with Naika on a routine basis, meeting and often surpassing procedural requirements. In addition, she remained empathetic with the mother and tried to foster a parent/child bond by offering emotional support so that she, in turn, could emotionally support Naika. This was further evident even after the mother relinquished custody in April 2016.

On several occasions, the case manager would encourage the mother to engage in treatment (e.g., individual therapy) as that was the only remaining task preventing Naika's reunification. While the efforts were not embraced by the mother, the case manager never stopped encouraging her to work towards reunification with Naika. In fact, on a scheduled day off in December, the case manager tried to arrange a holiday visit between Naika and her mother; however, her mother declined.

While placement disruptions made therapeutic service provision challenging, this did not seem to impact the bond Naika had with her therapist. This bond was evident as there were times when Naika would specifically request to see her therapist when she felt upset and needed to talk. The therapist noted that Naika never had any problems expressing her emotions; it was the regulation of her emotions that was the challenge.

Organizational Assessment

PURPOSE: This section examines the level of staffing, experience, caseload, training, and performance as potential factors in the management of this case.

The department contracts with Community-Based Care Lead Agencies (CBC) for child welfare services throughout the state. The CBCs then contract directly with case management organizations within their service area to provide services to families. Case management organizations then work with local providers, including medical and behavioral health professionals, to provide assessments and services to children and families in the community.

FINDING A: The child welfare professionals involved in this case were highly experienced and well prepared to perform their responsibilities; and while overall caseloads across the case management agency were slightly elevated, it did not have an impact in this specific circumstance.

The team encountered highly experienced and well prepared case management staff within the case management organization, Center for Child Enrichment (CFCE). The case manager earned a Bachelor's Degree in Social Work and completed an internship in the child welfare field before becoming a case manager in September 2015. She had been the assigned case manager who worked with Naika and her family since October 2015. Ongoing support and guidance was continually provided by the case management supervisor, who has 15 years of child welfare experience as well as a Master's Degree in Marriage and Family Therapy. Moreover, the agency's Program Administrator is a Licensed Clinical Social Worker with approximately 13 years of child welfare experience.

While the following case load summary provided by the agency details slightly elevated numbers (an average of 21 – 22 children per case manager) as compared to the contract measure of 17 children per case manager, this did not have an impact in the case manager's ability to meet the family's needs. In fact, the case manager often performed above and beyond procedural requirements.

Unit Statistics									
Unit 118852	Case Count (All)	Case Managers	Cases	Children	OOH Clients	Avg Caseload	Avg Child Count	Avg OOH Clients	Restricted Percentage
November, 2016	53	5	53	103	73	10.6	20.6	14.6	0.0%
December, 2016	55	5	55	106	82	11.0	21.2	16.4	0.0%
January, 2017	56	5	56	112	91	11.2	22.4	18.2	0.0%
	164	15	164	321	246	10.9	21.4	16.4	0.0%

Case Manager									
	Case Count (All)	Case Managers	Cases	Children ***	OOH Clients	Avg Caseload	Avg Child Count	Avg OOH Clients	Restricted Percentage
November, 2016	9	1	9	20	15	9.0	20.0	15.0	0.0%
December, 2016	8	1	8	19	12	8.0	19.0	12.0	0.0%
January, 2017	8	1	8	22	15	8.0	22.0	15.0	0.0%

(***) Case Manager Child count provided by CFCE from internal data. All other data was sourced from Safehaven/FSFN

Likewise, the attorney's within Children's Legal Services (CLS) were well prepared and had been involved in frequent hearings before the court with regards to Naika's case. The average caseload per CLS attorney in Miami-Dade County is 60 cases. While the American Bar Association recommends an average caseload of 50 cases, this is still lower than the statewide target of 80 cases.

Service Intervention/Array

PURPOSE: This section assesses the inventory of services within the child welfare system of care, primarily with regard to Naika's mental health treatment and level of care placement.

FINDING A: Over a nine-month period between April 2016 and January 2017, Naika experienced 14 placement changes, most of which resulted from behavioral disruptions. The number of

disruptions made engagement of wrap-around mental health services difficult in spite of the evident need.

When the mother relinquished custody of Naika resulting in her third entry into care in April 2016, Naika was initially placed in a shelter facility until a traditional foster home placement became available. During her initial placement, staff were cognizant of the importance in maintaining some level of stability and, as a result, made efforts to ensure that Naika continued to attend her regular school so that her academic progress would not be disrupted. While there were some behavioral issues noted during this placement, facility staff noted that Naika was responsive to redirection.

After six weeks, Naika was moved to a traditional foster home, which is when her behavior started to become more problematic. Over time, Naika would experience 13 additional placement changes. Many of these changes were due to behavioral disruptions, while others were due to a lack of providers willing to accept her into their homes on a long term basis due to her behavioral concerns.

In November 2016, Naika was approved for Specialized Therapeutic Foster Care and, until a placement could be identified, wrap-around support services were recommended to continue. While the CFCE therapist was able to re-engage with Naika during the times when placement was stabilized, continued instability negatively impacted on-going service provision.

The following details the number of placement changes:

Date of Placement	Placement Type	Length of Stay	Reason for Placement Change
4/19 – 6/2/16	Shelter Facility	6 weeks	Naika was placed in a traditional foster home.
6/3 – 6/13/16	Traditional Foster Home	10 days	Foster parent requested due to Naika not following rules and being disrespectful.
6/13 – 6/24/16	Traditional Foster Home	11 days	Foster parent requested due to Naika becoming verbally and physically aggressive.
6/24 – 10/7/16	Traditional Foster Home	Nearly 4 months	While this foster parent managed Naika's behaviors, she subsequently became physically aggressive [REDACTED] when she was caught with a cellular device.
10/7 – 10/11/16	Emergency Placement (Traditional Foster Home)	4 days	This placement was temporary. Foster parent was willing to assist while another home was sought, however, was not willing to keep Naika long term due to her behavioral issues. After 4 days, Naika ran away.
10/13 – 10/21/16	Shelter Facility	1 week	Naika was placed at the shelter facility upon her return from runaway status. She was moved one week later after she smeared feces on the wall, and was put on a "do not admit" list.
10/21 – 10/24/16	Emergency Placement (Traditional Foster Home)	3 days	This placement was temporary and was with the same provider from the 10/7 placement, however, could only keep Naika for a few days.
10/24 – 10/25/16	Emergency Placement (Traditional Foster Home)	1 day	This placement was temporary. Traditional Foster Home placement was still being sought. Foster parent was willing to assist, but not

			willing to take Naika long term due to her behaviors.
10/25 – 10/26/16	Emergency Placement (Traditional Foster Home)	1 day	This placement was temporary. Traditional Foster Home placement was still being sought. Foster parent was willing to assist, but not willing to take Naika long term due to her behaviors.
10/26 – 11/17/16	Traditional Foster Home	3 weeks	Foster parent was willing to work with Naika's behaviors, however, Naika subsequently ran away.
11/22 – 11/29/16	Emergency Placement (Traditional Foster Home)	1 week	Naika was placed temporarily after she returned from runaway status. She remained in placement for one week until a group home placement could be secured.
11/29 – 12/20/16	Group Home	3 weeks	Placement change due to Naika becoming physically aggressive. [REDACTED]
12/20 – 12/21/16	Emergency Placement (Traditional Foster Home)	1 day	Naika was placed temporarily [REDACTED]
12/21/16 – 01/22/17	Traditional Foster Home	1 month	Foster parent was willing to work with Naika's behaviors.

Of important note, in the midst of placement disruptions, the case manager asked Naika why she behaved the way she did even when she shared a positive relationship with her foster parent. Naika told the case manager that she thought she would get to go home like she did the last time she was in care (in 2014). It appears that Naika's issues were considered to be more behaviorally-based as opposed to unresolved trauma or an unresolved mental health condition when placement needs were considered. This was likely driven by the primary diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) as well as other conduct-related disorders. (Issues surrounding the mental health diagnoses will be further addressed in Finding C).

FINDING B: There is a shortage of Specialized Therapeutic Foster Care (STFC) homes available in the community. As a result, OurKids has begun to initiate strategies to improve service delivery by implementing internal therapeutic placement programs.

Specialized Therapeutic Foster Care (STFC) is a Medicaid treatment service for children/youth with serious emotional issues. The service includes therapeutic support by the foster parents to the child/youth, clinical services provided to the child and in support of the foster parent by a primary clinician and psychiatric services. These clinical services are provided by a Medicaid enrolled Behavioral Health provider. The foster parent receives the basic foster parent payment and additional funds from the Behavioral Health provider to support the therapeutic activities in the home. The STFC is provided in a licensed foster home.

Activities associated with recruitment and licensing of the foster home are usually initiated by the Behavioral Health provider of STFC. The provider typically recruits the home, completes the activities associated with licensure requirements, provides the foster home pre-service training, and sends the licensure package to the department for licensure. The Managed Medical Assistance (MMA) health plan credentials the Behavioral Health provider for STFC. When this process is used, the Community-Based Care Lead Agency (CBC) has very little involvement in the selection of the home or the type of clinical services provided.

However, it is possible that the CBC could be much more involved in the process. In fact, a partnership approach could result in better recruitment of foster homes and higher quality of services. Suggested partnership activities are listed below:

- CBC works with the MMA Medicaid health plan to expand the number of Behavioral Health treatment providers that wish to provide STFC in the area.
- CBC works with MMA and the Behavioral Health treatment provider to recruit foster parents who are good candidates to work with this population.
- CBC reviews the clinical approach with the MMA and the Behavioral Health treatment provider to ensure that it is evidence-based and will meet the needs of the children and youth.
- If additional training is needed to implement the evidence-based practice, the MMA and the CBC may partner to provide the necessary training for the foster parent and clinical staff.

There are currently four Specialized Therapeutic Foster Care entities in Miami-Dade that operate independent of OurKids, the CBC Lead Agency in the area: Citrus Health Network, Devereux, Pinnacle, and Community Health of South Florida. If a recommendation is made for STFC during the multidisciplinary team (MDT) staffing, OurKids' behavioral health unit, in coordination with the placement team, conducts the search. They first attempt to locate a placement within the county by referring the case to the local STFC providers. If unsuccessful, they will broaden the search to other counties.

Upon referring a case for STFC, these private providers first assess the youth for their respective program, after which time they will either recommend or deny admission. Should the admission be approved, the case is then presented to the potential foster parents who can choose to accept or decline placement. This process is then continued until placement can be secured.

In addition to the local population, STFC providers also accept youth for placement from other community-based care agencies outside of the county/region. While this is a common practice throughout the state, it further impacts placement availability for the local children in need. For example, of the 136 STFC beds, currently only 55 are being utilized for children being served within the OurKids network. While a number of these 136 beds may have to remain open at any given time due to licensing holds, issues with a specific foster home, selective foster parents, and safety plan reasons, a significant number of beds are being used for children from other areas of the state.

There were 25 children in the OurKids network awaiting placement in STFC as of February 21, 2017. Six of the children were age 12 years or younger, while 19 were age 13 years and above. In addition, female children accounted for 75% (19 out of 25) of the total number pending admission. The majority of youth on the wait list are currently in STFC, but are in need of a new placement due to disruption.

With regard to Naika, following the MDT staffing on November 9, 2016, at which time STFC was recommended, efforts to find placement for Naika were initiated the following day and continued on into December. The placement team also sought to secure a placement in Broward County through various entities; however, they had been unsuccessful in doing so.

Local providers are very aware of their need for additional STFC homes and Community Health of South Florida recently engaged in a major recruitment campaign. This campaign resulted in

the recruitment of more homes than they could effectively move through the training and licensing process, and in response, OurKids extended their support and staff to assist.

In addition, OurKids has three evidence-based programs in various stages of start-up, which will influence their ability to serve children with complex needs with the primary goal of creating a network of foster parents prepared to manage these children. They have two clinicians on staff who are implementing the 'Together Facing the Challenge' program which includes a training curriculum, as well as coaching and consultation. The agency recently completed their first train the trainer cycle and will continue to broaden this effort, ultimately incorporating the curriculum into pre-service training. A common concern of STFC is the necessity to transition out of this level of treatment once stabilized, resulting in a placement disruption from a foster family. OurKids hopes that Together Facing the Challenge will remedy this by enhancing the caregiving in traditional foster homes.

Next, OurKids is working with the model creators of an evidence-based program called Structured Decision Making System for Substitute Caregivers, which uses a set of key characteristics of parents and then matching appropriately with children in need of placement. They are currently in the planning phase and then their staff will need to undergo training before implementation.

Finally, OurKids is working with Treatment Foster Care Oregon to bring their evidence based model to Miami-Dade. OurKids has partnered with one of their case management organizations to cost share the implementation. The goal is to recruit and license 10 homes the first year to serve 10 youth. These youth must have a goal of reunification or another permanency plan that will be implemented at the end of the nine months of treatment. Each foster home will be served by a team, which includes a therapist and case manager. They are currently having weekly implementation calls and several homes are in process. OurKids expects that they will meet the goal of ten homes by the end of this calendar year (2017). In addition, OurKids hired a Foster Parent Advocate who is a licensed clinical social worker with extensive child welfare experience to support foster parents, as well as a PhD-level Research and Evaluation Manager to assist with the implementation and evaluation of the above mentioned evidence-based models.

While OurKids is taking the approach of developing and managing their own therapeutic homes, it would be beneficial to partner their efforts with a Medicaid-approved provider to ensure this level of service is appropriately charged to the managed care plans.

FINDING C: Treatment for Naika focused primarily on the symptoms of her trauma rather than addressing the trauma itself.

Psychologically and chronically traumatic experience(s) appeared to present themselves through a wide variety of events in Naika's life, such as (but not limited to) abandonment, rejection, abusive relationship, assault, and alleged sexual abuse. Therapy for Naika appeared to be primarily directed at the prevention of predatory or sexually reactive behaviors, inattention and challenging behaviors. The ongoing nature of Naika's challenging behaviors contributed to the instability of her placements.

With regard to specialized treatment to address trauma, many traumatized children are not correctly identified and those who are receiving treatment do not typically receive evidence-based treatments. Evidence-based treatment interventions for sexually abused children need to be individualized and address the sexually abused child's developmental history within the family, community, and cultural context. Ongoing treatment may then focus on more nuanced

and pervasive attachment-related issues, such as difficulties with emotional regulation that usually stem from other complex trauma experiences. Although Naika received treatment from a provider(s) with expertise in treating victims of childhood sexual abuse, it is unclear, based on the information available, if the interventions used were evidenced-based and designed to address complex trauma and promote healing. In addition, based on information available to the review team, it appears that treatment received by Naika was inconsistent and sporadic.

Lastly, there was a noted concern regarding possible inaccurate and multiple diagnoses. Naika's primary diagnosis consistently remained Attention Deficit Hyperactivity Disorder (ADHD). An ADHD diagnosis for a child who has suffered trauma, however, comes with its challenges, including how often symptoms of trauma in young children mimic those with ADHD. A psychological evaluation conducted with Naika stated that *there is much concern that her attention problems are due to anxiety and trauma rather than ADHD symptomatology* and recommended further evaluation to clarify the ADHD diagnosis. However, it does not appear that further evaluation was conducted. In addition to the ADHD diagnosis, Major Depression, Post Traumatic Stress Disorder and Disruptive Mood Dysregulation Disorder were given by various treating mental health professionals over the course of Naika's life. However, limited documentation within the assessments does not appear to support these diagnoses or the medication prescribed. An additional consideration is the cascading effect of a diagnosis, which drives the development of the treatment plan.

FINDING D: The provision of mental health-related services was fragmented, with limited information sharing among the various treatment providers and other individuals providing services to Naika.

During the course of the CIRRT process, reviewers noted that mental health treatment records were not always shared, even when requested, resulting in a barrier not only with regard to on-going service provision, but also with regard to the completion of the CIRRT review itself.

Multiple providers delivering services outside of a multidisciplinary approach can be contraindicating, delay appropriate service provision and limit coordination. There were multiple individuals and agencies responsible for Naika's welfare that did not appear to communicate regularly, effectively or accurately, based on a review of available records. Reports on her behavior, medication, and life changes were not fully and consistently shared among those charged with maintaining her treatment and ensuring her well-being. After reunification, there appeared to be a lack of continuity of service provision, based on disruptions in services when the mother stopped taking Naika to her appointments; these disruptions ultimately negatively impacted the gains that had been made.

FINDING E: There was a pattern of dysfunctional/unhealthy interactions between Naika and her mother that was not effectively addressed due, in part, to the mother's level of non-compliance.

The mother, herself, was traumatized during her own childhood, and as an adult, she struggles with emotional control and anger. While she underwent various evaluations, and attended [REDACTED] programs, the mother failed to engage in more intensive therapeutic interventions that had been recommended. Likewise, the mother inconsistently participated in or supported Naika's treatment, which likely contributed to Naika's limited success. In addition, there were indications of a substance use disorder that did not appear to be assessed.

Based on a review of the available records, reviewers noted that it is possible that the mother has a personality disorder, or at least pathological personality traits, based on a pattern of projection and possible manipulation [REDACTED]. If that is the case, more intensive psychotherapy and possibly psychopharmacological interventions would have been indicated. But again, reviewers noted, if she did not embrace the services that were provided, she likely would not have engaged in more intensive and specialized services.

Lastly, consideration of this family's cultural beliefs and norms would have been beneficial when matching this family to treatment providers and approaches.

Summary

Effectively navigating a complex behavioral health system to access the right services provided by professionals with specific expertise, understanding issues related to psychotropic medications, and identifying warning signs and risks associated with increased suicide risk, can be a challenge. Likewise, recognizing the impact of trauma, knowing how to interact in a trauma informed manner, accessing evidenced-based treatment, and ensuring the quality of treatment provided can also be difficult.

The impact of multiple risk factors can create cumulative risk, which was present and evident in Naika's case. Of particular interest, is Naika's exposure to multiple forms of victimization, maltreatment, and poor familial environments (parental monitoring, transitional living/multiple placements), which are key suicidal risk factors. In Naika's case, the above protective factors (strong/influential enough to give the youth hope and something to keep living for) were not consistently present in her life, and it appears that Naika did not possess resilient traits to keep her safe.

Social media forums can incite online peer pressure (e.g., observers egg on or encourage individuals to carry out harmful acts, like suicide and other risky behavior), something that happened in Naika's case. An additional consideration is that within the last year, there were three suicides captured live, the last of which occurred in December 2016 in Georgia by a 12-year-old girl. Although it is unknown whether these deaths influenced Naika, given the proximity of time between the last reported suicide and Naika's death, reviewers noted that contagion is suspect.

Extensive care coordination to youth at risk of suicide (e.g., youth who present with suicide risk factors; youth who have verbalized suicidal threats; youth who have been Baker Acted) is needed, as is the use of evidenced-based safety plans and best practice assessment tools that assess suicide risk.