



COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

COLORADO PUBLIC MEETING HIGHLIGHTS—SEPTEMBER 22-23, 2014

The Commission to Eliminate Child Abuse and Neglect Fatalities held a public meeting at the Denver Federal Center in Colorado on September 22-23, 2014. The purpose of this meeting was to explore what is known about fatal child maltreatment risk factors and examine Colorado's strategies for preventing deaths from child abuse and neglect. More than 200 people attended via teleconference or in person. This brief provides highlights from the meeting, including key points on the following:

- Child abuse and neglect fatality etiology research
- Colorado's child welfare reform
- Assessing child safety
- Multidisciplinary prevention strategies in Colorado
- Commissioner deliberations

The meeting opened with presentations by a parent advocate and two youth advocates with strong messages for the Commission about the importance of prevention funding, a supportive approach to families, and the inclusion of parent and youth voices in policy, program, and funding decisions. The parent advocate, Toni Miner, described her experience as a young methamphetamine addict raising two daughters. She has been clean for 13 years; however, her daughters are now struggling with addictions of their own. Miner, who is raising her grandchildren as well as a young son, believes that the availability of trauma assessment and treatment services when she was involved with the child welfare system might have stopped the intergenerational cycle of substance abuse and system involvement.

The two former foster youth, Diego Conde and Daryle Conquering Bear Crow, are both affiliated with FosterClub. They spoke movingly about the loss of identity that occurs when children are removed from their families, tribes, and protective cultural practices, and of the potentially tragic results of these losses, including youth who succumb to drug addiction and suicide. The Commissioners were urged to hold a future meeting on a reservation, to learn more about the experiences of Native American youth in foster care and to hear from families whose children have been removed.

CHILD ABUSE AND NEGLECT FATALITY ETIOLOGY RESEARCH

The meeting's first panel presentation included remarks by some of the nation's leading researchers who are studying the individual and community risk factors that place children at risk, as well as those that protect children from abuse and neglect fatalities.

- **Brett Drake, Ph.D.**, a former child abuse investigator and long-time researcher in the field, discussed the idea that while there is no clear set of risk factors that can predict which children will die from abuse or neglect, there are many commonalities among cases. Some of the risk factors consistently identified in research include prior CPS reports and low

socioeconomic status. His suggestions for prevention included quickly identifying young children with socially isolated parents, combining and accessing data from child welfare and other data systems in real time (through strategies such as birth match), and offering voluntary services to young families with multiple risk factors.

- **Desmond Runyan, Dr. P.H.**, director of the Kempe Center, compared the risk factors for parental self-report of harsh punishment to risk factors for report of nonfatal and fatal physical abuse as defined by CPS. He pointed out that the most striking difference is that children who die from physical abuse are younger. He also spoke about a study of harsh punishment in 19 countries around the world, which found that maternal education was protective against punishment and the correlation was very strong.
- **John Fluke, Ph.D.**, associate director for systems research and evaluation at the Kempe Center, provided an overview of the primary sources of child maltreatment data in the United States. He observed that U.S. children are at greater risk for child maltreatment death compared to children in other high-income countries, but the experience of these other countries indicates that maltreatment fatalities can be reduced. Dr. Fluke argued that the nation's approach to measurement and prevention should be consistent with public health principles, definitions, and strategies. He also urged the Commission to address potential conflicts between public health principles and U.S. values. He gave two examples of such value conflicts: (1) punishing families who inadvertently leave children to suffocate in hot cars, rather than creating a technological solution that could prevent these deaths altogether, and (2) resistance to increasing families' access to health care.
- **Gary Melton, Ph.D.**, professor of pediatrics and co-editor of the journal *Child Abuse & Neglect*, argued that current research tends to overemphasize individual perpetrator factors at the expense of community and environmental factors. Dr. Melton urged the Commission to revisit the U.S. Advisory Board on Child Abuse and Neglect's 1993 report, *Neighbors Helping Neighbors*, which proposed a neighborhood-based strategy for child protection. It is based on the assertion that the strongest factors in child maltreatment cases are not individual but communitywide, including economic poverty and "social poverty" (lack of social connection). This strategy was operationalized in the Strong Communities for Children initiative in South Carolina, with positive results that included declines in substantiated child maltreatment reports, ER visits, and hospitalization rates.
- **J. Christopher Graham, Ph. D.**, a statistician at the University of Washington, asserted that many child abuse and neglect fatalities are prevented every day. Risk factors do not occur in isolation—for example, a dangerous situation may turn out to be protective for a child if it captures the child welfare system's attention and brings help to the family. Dr. Graham stressed the significance of understanding interactions among risk factors in increasing the power of risk profiling. Data systems, therefore, need to capture more information about the conditions surrounding child deaths. He also argued that the public health approach and investigative approach are not mutually exclusive: A more complex understanding of the specific syndromes within families that have led to children's deaths will enable systems to justify appropriate interventions and treatment to prevent fatalities more effectively.

COLORADO'S CHILD WELFARE REFORM: KEEPING KIDS SAFE AND FAMILIES HEALTHY 2.0

Recent reforms to the child welfare system in Colorado, including Governor John Hickenlooper's new master child welfare plan, Keeping Kids Safe and Families Healthy 2.0, were referenced frequently throughout the two-day meeting.

On Monday morning, Julie Krow, director of the Office of Children, Youth, and Families at the state's Department of Human Services (DHS) and incoming president of the National Association of Public Child Welfare Administrators spoke alongside Dr. Larry Wolk, executive director and chief medical

officer of the Colorado Department of Public Health and Environment. They emphasized the importance of interagency cooperation, noting that although their departments maintain separate child fatality prevention and reporting systems, those systems are now required to work together and produce joint recommendations. They recommended that this kind of shared community responsibility for fatality prevention be encouraged nationwide, through joint funding, standardized definitions, and requirements for data sharing. Krow cited the innovative work of the National Electronic Interstate Compact Enterprise (NEICE), in which state child welfare systems are able to exchange case data electronically for the purpose of processing Interstate Compact for the Placement of Children cases across state boundaries. Both speakers urged funding for prevention programs such as nurse home visiting, parenting skills education, high-quality early childhood education for children in the child welfare system, and widespread implementation of CDC's *Essentials for Childhood*.

Also on Monday, the Commission was addressed by two state legislators, Colorado Sen. Linda Newell and Rep. Jonathan Singer, who summarized the legislature's role in recent reforms. Recent bills have established or significantly enhanced the state's child welfare training academy, ombudsman's office, child fatality review teams, and office of early childhood, among others. Rep. Singer, a former child welfare worker, focused his remarks on the importance of caseworkers' workload, tools, and training. Sen. Newell made several appeals for enhanced federal support to states, including:

- Funding for kinship care
- Guidance regarding state child protection ombudsman offices
- Further support for efforts to prevent and address human trafficking
- A "child's bill of rights"
- Easier access to mental health services
- Research and data on the effects of marijuana use on children's developing brains

On Tuesday, the Commission was joined by Reggie Bicha, executive director of Colorado DHS and president of the board of directors of APHSA. He stated that Colorado is making extraordinary efforts to improve its child welfare system, expand its focus on prevention, and enhance transparency. He also noted that Colorado is one of only two states in the country that now requires review of "egregious incidents" of maltreatment that do not result in a fatality. He made five recommendations to the Commission:

- Require applied training for child welfare caseworkers.
- Modernize SACWIS systems.
- Monitor quality of practice, not just case documentation and policy compliance, in review systems.
- Support the creation of multidisciplinary teams for every child in foster care.
- Institutionalize flexibility in federal child welfare funding that allows states to focus on prevention and maintain children safely in their own homes whenever possible.

ASSESSING CHILD SAFETY

A panel on safety assessment included representatives from a variety of child- and family-serving systems, including David Olds, Ph.D., the developer of the highly regarded Nurse-Family Partnership (NFP) program, as well as experts in child welfare, substance abuse, and domestic violence.

Dr. Olds discussed the development of the NFP, including research findings about its effectiveness. He emphasized that the program was not established specifically to prevent child abuse and neglect;

instead, its goal is to improve child and maternal health. NFP has shown evidence of positive outcomes, including reductions in injuries and maltreatment; however, Dr. Olds strongly emphasized the importance of program fidelity—the program’s effects are considerably smaller, for example, when paraprofessionals rather than nurses provide the same in-home services.

Paige Rosemond, child protection services manager for the Division of Child Welfare within Colorado DHS, outlined how Colorado’s state-supervised, county-administered system assesses safety and risk in child protection cases. Key points include the following:

- Each report of abuse or neglect is assessed by a RED (Review-Evaluate-Direct) team, which assesses whether the report meets the state’s definition of abuse or neglect and considers both safety and risk in assigning an appropriate response time.
- Colorado now has a mechanism for providing referrals to community-based resources, even for those cases screened out of the child protection services system, recognizing that many of these families have needs and will return to the system if those needs are not addressed.
- Safety and risk continue to be reassessed throughout the life of an open case, whenever there is a change within the family (e.g., a new paramour in the home).
- Family service plans emphasize child safety and the importance of family and community.
- Current caseloads do not permit child welfare workers to know the families on their caseload as well as they need to in order to better assess safety and risk factors.

Kathryn Wells, M.D., spoke about substance abuse, which is present in approximately 12 percent of all homes with children and is a factor in a high percentage (70-80 percent) of child welfare cases. Substance use impacts caregivers’ judgment and priorities; it also can place children in dangerous environments, including exposure to drugs, crime, and violence. There may be a unique opportunity to intervene with pregnant women, who often experience an incentive to quit and decreased use, up to their baby’s third month. Dr. Wells also discussed the unique risks posed by Colorado’s recent legalization of marijuana, which appears to be resulting in an increased number of unintentional exposures, among other consequences. She emphasized the importance of information-sharing among systems; access to effective treatment services; and training for all professionals that touch families affected by substance abuse, including the prison system.

Elizabeth Collins presented on the unique issues involved in the approximately 40 percent of child maltreatment cases that involve domestic violence. She argued that child welfare staff need to know more about how to address these cases; this can be facilitated through the co-location of domestic violence advocates within child welfare units. Child welfare workers also need to employ a trauma-informed approach when engaging and working with adult victims, and to recognize that reunification of offender parents into families may not be safe for children.

MULTIDISCIPLINARY PREVENTION STRATEGIES IN COLORADO

Throughout the day on Monday, the Commission heard about a variety of multidisciplinary strategies to prevent and investigate child fatalities. Stakeholders from various child- and family-serving systems offered an in-depth look at those systems, including child fatality review and the state’s Administrative Review Division.

Commissioners heard from stakeholders in El Paso County, where a broad, community-based effort, the Not One More Child Coalition, was initiated after the county experienced 10 deaths due to abuse or neglect in 2011. Most of those fatalities were the result of abusive head trauma, and the majority occurred within military families. The coalition includes representatives from DHS, law enforcement, public health, the military, nonprofit organizations, hospitals, schools, emergency services, and the

media, among others. Their efforts are concentrated into seven task groups that address public awareness/communication, data, and hotline services, as well as groups with particular focus on the faith-based community, first responders, the medical community, and the military. The military group has created a popular Boot Camp for New Dads program that includes the use of program graduates as mentors for other new fathers, in addition to reintegration and other support. Data sharing and the use of memoranda of understanding are other important components. The approach appears to be contributing to a reduction in child fatalities: The county reported three deaths in 2012, four in 2013, and only one so far in 2014.

Finally, the Commission heard from two panels of stakeholders about the state's strategies to prevent child maltreatment fatalities to children both known and unknown to the child welfare system. Many of the issues these presenters raised have been voiced consistently at this and other state meetings. Some of their recommendations include:

- Provide additional support and connection for families through networks of health care systems. Encourage information sharing between the health care and child welfare systems.
- Support comprehensive, coordinated approaches to supporting families; incentivize collaboration among different social service agencies/providers.
- Look at child abuse and neglect fatalities through a racial equity lens; ensure assessment and prevention strategies are culturally relevant and address the impact of historical trauma.
- Incorporate resilience. Ask families, "What's working? How can we help make it work better?"
- Mandate autopsies in all child fatalities under age 5, and require the involvement of specialized child medical examiners with appropriate medical expertise and training.
- Ensure that juvenile courts are overseen by committed, well-trained judges.

COMMISSIONER DELIBERATIONS

The Commission spent most of the second day of this meeting in internal deliberations. Commissioners reviewed several case studies, shared their own backgrounds and the knowledge and skills that they bring to the Commission's work, and then discussed potential topics to explore more deeply in the next few months. Six priority areas emerged from this discussion: counting (including child fatality review), current federal policy and funding, the public health approach to prevention, "red-button" child welfare cases (high-risk cases already known to the child welfare system), Indian child welfare, and the military. These topics will be explored by subcommittees of Commissioners, who will report their progress at the next meeting in October.

A full transcript and meeting minutes will be available on the Commission's website at <https://eliminatechildabusefatalities.sites.usa.gov/>