



COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

SUMMARY OF PUBLIC MEETING SEPTEMBER 22-23, 2014

Meeting Location: One Denver Federal Center, Denver, Colorado
Building 41—Remington Arms Room (1st floor)

Commissioners Present: David Sanders (Chairman), Amy Ayoub, Cassie Statuto Bevan, Theresa Covington, Susan Dreyfus, Patricia Martin, Michael Petit, Jennifer Rodriguez, David Rubin, Marilyn Zimmerman

Commissioners Attending by Phone: Bud Cramer, Wade Horn

Designated Federal Officer: Liz Oppenheim, Chief of Staff

Conduct of the Meeting: In accordance with the provisions of Public Law 92-463, the Commission to Eliminate Child Abuse and Neglect Fatalities held a meeting that was open to the public on Monday, September 22, 2014, from 8:00 a.m.-5:00 p.m. and Tuesday, September 23, 2014, from 8:00 a.m.-2:30 p.m. at the Denver Federal Center. The purpose of the meeting was for Commission members to explore what is known about fatal child maltreatment risk factors and examine Colorado's strategies for preventing deaths from child abuse and neglect. Commissioners heard from prominent researchers and state stakeholders on five topics: (1) What we have learned about risk factors for child abuse and neglect fatalities and what additional research is needed, (2) How different social services assess the risk of fatal maltreatment in the families they serve, (3) Colorado's multidisciplinary approaches to working with families before a fatality and conducting joint investigations of fatalities when they occur, (4) Colorado's strategies for preventing child abuse and neglect fatalities *before* any maltreatment is known nor suspected, and (5) How the child welfare system in Colorado works to prevent child maltreatment fatalities once abuse or neglect has been suspected or determined.

Chairman Sanders informed participants that the agenda was very tight and that he was going to keep closely to the times allotted for each presentation. He indicated that audience members would not have the opportunity to ask questions during the proceedings and requested that audience members not engage in direct dialogue with the Commissioners. Finally, he indicated that any audience members wishing to comment could leave written testimony in the designated file at the registration table or submit testimony or written feedback through the Commission's website.

MONDAY, SEPTEMBER 22, 2014

OPENING REMARKS

Chairman David Sanders, CECANF

Dr. Sanders introduced the Commission and its mission. He explained the goals for the public hearing in Denver. Commissioners introduced themselves.

PARENT AND YOUTH PRESENTATIONS

Toni Miner, Parent Advocate

Toni Miner shared her personal story of her recovery from methamphetamine addiction and how her addiction affected her family. She currently serves on a range of policy committees for system reform, in Jefferson County and statewide. Miner offered five recommendations for improving child welfare practice and eliminating fatalities:

- Make prevention a priority and invest the necessary funding. Too often when money is tight, prevention programs are the first to be cut.
- Use a strength-based, supportive approach to help families keep their children at home safely and build protective factors.
- When children cannot stay safely at home, kinship care should be used whenever possible.
- Realign federal child welfare funding to match the needs of families, including increased flexibility.
- Partner with parents who have successfully left the system to work with families who are currently in the system. Give parents a voice in child welfare policy and programs.

Daryle Conquering Bear Crow, FosterClub, American Indian/Alaska Native Youth Advocate

Conquering Bear Crow pointed out that he is both an American Indian and an American citizen. Yet despite the Indian Child Welfare Act (ICWA), when he was in the Colorado foster care system, he was cut off from his culture and his family. ICWA is underfunded and not understood. Native American youth are suffering; suicides take place every day. He urged the Commission to hold a public hearing on a reservation.

Diego Conde, FosterClub

Conde spoke of losing connection to his Latino culture when he was in foster care. He experienced abuse and neglect in care, but he also learned it is difficult to be a foster parent. He believes many problems are due to miscommunication. He called for a curriculum for foster parents and youth to help them understand each other's culture and to support foster youth in following their passion.

Commissioner Discussion

Commissioners' questions and comments led to the following suggestions:

- More parent partners and recovery coaches can help families in the system open up, ask for help, and get support as early as possible. Those who have been in the system can tell when parents are lying and hold them accountable. It is also important that caseworkers not judge parents.
- Judges and court personnel need to take the time to get to know parents and youth as individuals.
- To help reduce fatalities on Indian reservations, give tribes more resources to run their own programs. Psychotropic medication for youth is not the answer. More ceremonial traditions will help.
- The Latino culture is very family-focused, but foster families housing Latino foster youth often do not talk to one another. It is critical to break down this taboo and open communication across cultures.

WORKING TOGETHER AT ALL LEVELS OF GOVERNMENT TO PREVENT CHILD ABUSE AND NEGLECT

Julie Krow, Director, Colorado Department of Human Services (DHS), Office of Children, Youth and Families; President Elect, National Association of Public Child Welfare Administrators (NAPCWA)

Krow's appointment as director of the Office of Children, Youth and Families coincided with a high-profile media investigation into child fatalities in the state. This investigation was an impetus for both the community and the legislature to transform the child welfare system. The response was the governor's Child Welfare Master Plan, which included nearly \$30 million to support prevention initiatives. Programs include the following:

- SafeCare Colorado, an evidence-based program that supports families screened out of the system but who need help building parenting skills
- Extension of the Nurse-Family Partnership program to families in the child welfare system
- A community response program for voluntary services and parent education
- Support for in-home family preservation

Additional relevant developments in the state include the following:

- The state has a title IV-E waiver to test innovative front-end programs to reduce congregate care, promote permanency, and better identify children who need trauma-informed care.
- Colorado's child welfare system is county-administered and state-supervised. In January, the state will roll out a statewide hotline linked to its Statewide Automated Child Welfare Information System (SACWIS). Every county received training in enhanced screening and invested in a statewide public awareness campaign to coincide with the launch of the new hotline.
- The state overhauled its Child Welfare Training Academy and distributed more than 1,000 mobile technology devices to county child welfare staff.
- To focus specifically on prevention of child maltreatment deaths, the state refined the criteria for a full review by a child fatality review team and increased attention on near fatalities and egregious incidents.

Krow urged the Commission to consider several specific recommendations:

- Provide more federal government support for flexible and cross-system funding. Prevention of fatalities is not the responsibility of child welfare alone.
- Fund investigative teams that include workers from different systems (e.g., nurses, educational experts), so child welfare social workers do not have to be all things for all families.
- Support funding for public schools to teach parenting skills.
- Offer more parenting education for kinship, foster, and adoptive parents.
- Provide more support for reform of data systems, both internally and across state lines.

Dr. Larry Wolk, Executive Director and Chief Medical Officer, Colorado Department of Public Health and Environment (DPHE), pediatrician

Dr. Wolk's key points included the following:

- Child maltreatment is not just a child welfare issue. Especially when it comes to prevention, public health is part of the solution.
- Leaders should focus on evidence-based efforts and not be swayed by political pressures.
- In Colorado, there are 48 local child death review teams and one state team with members representing a variety of disciplines.
- DPHE's focus includes attention to safe sleep efforts and a call for more resources for the state's child welfare plan.

- Colorado is one of five states implementing the Centers for Disease Control and Prevention's (CDC's) Essentials for Childhood to promote relationships and environments that help children grow up to be healthy and productive citizens.
- Recommendation: Increase funding for primary prevention.

Commissioner Discussion

Commissioners' comments and questions yielded the following points:

- Most children who die from maltreatment are in the Medicaid system, even if they are not known to child welfare. Can Medicaid be more proactive in identifying vulnerable children and getting help to them? Dr. Wolk mentioned Colorado's health information exchange, which links every hospital in the state and can be used to identify these children earlier.
- The state is reviewing the county memorandums of understanding with law enforcement with an eye toward improving integrated teaming. Krow would like to see Colorado's SACWIS system flag child protective services (CPS) if there is a law enforcement incident and would like teams to include nurses, as well as child welfare and law enforcement.
- The state's SACWIS system was recently modified to test the impact of spending on prevention.
- The state is working to align its early childhood program with its nurse home visiting program to help identify at-risk families before involvement with the child welfare system.
- Online mandated reporting training is statewide and includes a focus on reaching nurses and public health practitioners.
- Cases where domestic violence is present and offenders are in the home require better collaboration between child welfare and law enforcement. Krow pointed out that the state is working to strengthen the rules around domestic violence. They moved the state's domestic violence division from behavioral health into the child welfare department specifically because so many child fatalities were related to domestic violence.
- Public school programs on healthy parenting do not yet exist in the state, but both Krow and Wolk believe there is support for the idea.
- Colorado is looking to support young parents who grew up in the system themselves with a home-based, proactive approach. For example, investigators from different systems go into homes to check for problems such as radon, asthma, or lead. Safety of children could be part of an overall approach. The state also is looking at innovative opportunities to provide affordable housing and case management by nurses to reach this vulnerable population of young parents.

CHILD ABUSE AND NEGLECT FATALITY ETIOLOGY RESEARCH: WHAT HAVE WE LEARNED? WHAT HAVE WE YET TO LEARN AND WHERE DOES ETIOLOGY RESEARCH GO FROM HERE?

This panel presented research findings on the individual, family, community, and societal factors associated with child abuse and neglect fatalities and implications for prevention, intervention, and future research.

Brett Drake, Ph.D., Professor of Social Work at Washington University

Dr. Drake is a former child abuse investigator and has been a researcher in this field for the past 20 years. His key points included the following:

- There is no clear etiology of child abuse and neglect fatalities. However, there are some commonalities among cases. Ways in which fatal and nonfatal maltreatment tend to be similar include the following:
 - 80 percent of perpetrators of fatal and nonfatal maltreatment are biological parents.

- Child maltreatment fatality (similar to nonfatal maltreatment) is most commonly related to neglect.
- Fatal and nonfatal maltreatment differ in the following ways:
 - Fatal maltreatment tends to happen before the child's 2nd birthday. This is significant because it means there is not a lot of time for prevention efforts.
 - Fatal maltreatment often involves multiple types of maltreatment.
 - Fatal maltreatment is a relatively rare event. There are 75 million children in the U.S., with approximately 1,600 child maltreatment deaths/year.
- There are different types of child maltreatment fatalities, and we have yet to develop a well-specified theory that can explain the large variability across the entire population. Existing theories explore psychological, dyadic, and environmental factors.
- Some of the causal/associated factors appear to include the following:
 - Child issues (low birth weight, small gestational age, prematurity, and behavior issues)
 - Familial issues (young parents, low parental education, poor parental mental health, stress, social isolation, depression, substance abuse, authoritarianism, inappropriate expectations for the child, no father present, nonrelatives in the home)
 - Ecological issues (poverty)
- Risk factors are similar for fatal and nonfatal maltreatment, but fatal maltreatment cases may have more (and more serious) risk factors. What makes risk factors most useful?
 - They are most useful if we have the information already.
 - The best predictors apply to all major mechanisms of maltreatment.
 - The most useful factors have a high predictive power (increase risk many-fold, not by 20 percent or 50 percent)
- Examples of useful indicators appear to be prior reports, socioeconomic status (poverty is not a cause but is a good indicator), and non-CPS prior reports (e.g., medical records, arrests).
- Suggestions for prevention:
 - Speed matters: We need to get to young kids with socially isolated parents.
 - Data are underused. Information from child welfare and other systems should be combined and accessed in real time (e.g., birth match).
 - Getting voluntary services to young families with multiple risks is a good idea (not just for the value of the services, but also for getting eyes on those families).

Desmond Runyon, M.D., Dr.P.H., Pediatrician, Epidemiologist, and Director of the Kempe Center

Dr. Runyon shared findings from self-report surveys of harsh punishment by parents in North and South Carolina and Colorado. The rates found in this study are dramatically higher than official child abuse reports: roughly 4.5 percent of children. Self-reported abuse peaks with much older children—ages 9 to 12. Girls were more often reported to be victims than boys. Peak maternal age was relatively young, 20-25, and single parents were found to be at higher risk. In North and South Carolina, income was found to have little relationship to harsh punishment; this relationship was found in Colorado.

Dr. Runyon provided the following contrast between the epidemiology of fatal and nonfatal child abuse:

- Nonfatal: peak child age is 6.3 years, 51 percent female, 31 percent oldest or only child, unmarried parents, and maternal age 20-25. There is less risk to the child in a single-parent household.

- Fatal: 57 percent are less than 2 years old, 40 percent female, 31 percent oldest or only child, mean maternal age is 29 years. There is a higher risk if the mother is unmarried but with a partner, and similar to nonfatal abuse, a lower risk if the child lives with a single parent.

Dr. Runyon also shared the following findings from a study of abusive head trauma in a military birth cohort:

- Enlisted men were at 12x higher risk than officers.
- The highest risk was found in dual military-enlisted homes.
- The stress of deployment and from disasters both increase the risk.

Final points: A recent study of the Period of PURPLE Crying program among military and civilian populations found no change in hospitalization rates following parent education programs. Dr. Runyon suggested that from a global perspective, education of girls and delayed childbearing are significant protective factors.

John Fluke, Ph.D., Associate Director for Systems Research and Evaluation, Kempe Center

Dr. Fluke's presentation discussed sources, trends, and limitations of national child maltreatment data, as well as the implications of international comparisons. Questions addressed included: In what ways are current national data useful? Can they be translated into insights that are useful for policy?

- The two data sources he discussed were the National Child Abuse and Neglect Data System (NCANDS) and data available through the CDC.
 - NCANDS data include deaths reported to CPS agencies, and they vary greatly depending on state and local definitions and policy.
 - CDC data are based on a specific cluster of ICD codes. They do not typically address neglect-related deaths. However, they do include some conditions that a CPS agency would not typically report.
- Data show that our current approach to maltreatment fatalities does not appear to be working.
- International comparisons show that U.S. children are at greater risk compared to other high-income countries. Implications:
 - Prevention is key. Public health strategies seem most likely to reduce maltreatment fatalities; other approaches have not worked.
 - Experience of other countries indicates that maltreatment fatalities can be reduced.
- Dilemma: Can we develop public health strategies that are not in conflict with our values?
- Measurement strategies need to be consistent with public health principles.
- U.S. values may create barriers but also offer opportunities to create solutions that are unique to the United States. Need to identify short-term solutions that are "value neutral" and long-term solutions that address these values.

Gary Melton, Ph.D., Professor of Pediatrics, Kempe Center

Dr. Melton began his presentation with two caveats:

- As the co-editor of the journal, *Child Abuse and Neglect*, Dr. Melton believes that the field does not have and is not conducting the research we that is truly needed. Using the last three issues as an example, he argued that there are many papers on the effects of maltreatment, but very few on policy, safety, or the context in which maltreatment occurs. There is almost no useful research on fatalities, for three reasons:
 - It is difficult to look at fatalities on a community level, when there are so few that occur.

- Research tends to overemphasize individual factors and underemphasize situational factors. Looking for individual factors won't work because there are no "syndromes" for maltreatment.
- There is very little funding compared to other public health issues.
- Dr. Melton was vice chair of the U.S. Advisory Board on Child Abuse and Neglect in the 1990s. The board's 1993 report, *Neighbors Helping Neighbors*, proposed a neighborhood-based strategy for child protection. It postulated that the answer isn't hiring social workers but changing everyday life.
 - The study found that the strongest factors in the prevalence of maltreatment are not psychological but economic poverty and "social poverty" (lack of connections). For example, community-level indicators include liquor licenses (positive correlation) and child care licenses (protective correlation).
 - Physical characteristics of a neighborhood (observable just by driving through) account for 30 percent of the variance in hospital admissions related to abuse, controlling for demographics.
 - Good news: There are things we can do. The "Strong Communities for Children" initiative is the operationalization of the 1993 recommendations, during an eight-year period in South Carolina. Goal: Every child, every parent ought to know that if they had a reason to celebrate, to worry, or to grieve, somebody would notice and somebody would care. Results:
 - Substantiated reports went down.
 - Biggest changes were seen for the youngest children and prevention of neglect.
 - ER visits and hospitalizations went way down.
 - Perceptions of safety increased.
- Recommendation: Implement full-scale efforts with these kinds of principles behind them. Engage the whole community in building safety for kids, making child protection part of everyday life.

J. Christopher Graham, Ph.D., Statistician, University of Washington

Dr. Graham has studied caseworker decision-making and is one of the authors of the Texas Child Fatalities Study. The main points of his presentation included the following:

- Many child abuse and neglect fatalities are already prevented by the child welfare system every day.
- We know that being reported for abuse is a risk factor for fatality. However, *not* being reported when there is a danger can also be a major risk factor. When there is immediate danger or severe harm, a report can be a protective factor, because action is then taken to protect the child.
- By contrast, some factors that would appear to be protective, such as a "cooperative" caregiver, can also be dangerous by giving the caseworker a false sense of security.
- We can now do a pretty good job of predicting families at highest risk, but identifying risk factors is not enough—we need to really understand what is happening within families in order to justify intervention and treat the family. Just removing the child may not be the best approach.
- We need to understand not just risk factors, but interactions among these factors and the patterns of risk factors over time.
- Many of the risk factors for fatalities are the same as those for maltreatment, just at a different level of intensity.
- Fatality is an outcome, not a disorder. In order to prevent deaths, we need to understand the particular syndromes that lead to that outcome. Data systems need to capture more about the conditions in which deaths are occurring.

- We need both a public health approach and an investigative approach—predictive analytics *and* clinical judgment. Both can inform each other.
- We need to integrate multiple systems of data in order to advance our understanding of etiology, and then involve multiple systems of care to prevent fatalities based on this broadened understanding.

Commissioner Discussion

Commissioners' comments and questions yielded the following points:

- Combining or comparing states introduces error, due to differences in policy and definitions. States are often not comparable. At the same time, researchers working in different states often come to similar conclusions.
- With such a rare phenomenon (2 in 100,000 children), it can be difficult to narrow down to a group that could reasonably be addressed by an intervention. Most of the children who die are on some kind of public assistance, so that's a place to start. The more predictive factors you can identify, and the more elements you can put into a model, the better opportunity you have to narrow the number down. On the other hand, a more universal approach acknowledges the fact that most people experience some level of risk, and those risks are sometimes unpredictable. We also need to address the level of disconnection that many families experience.
- Some of the U.S. values that might be in conflict with effective prevention strategies include: (1) Stigmatizing families when children suffocate in vehicles, rather than focusing on developing technological solutions; and (2) limited access to health care.
- States can go further toward integrating lessons learned from the child fatality review process into training for caseworkers. Those findings should be integrated (through the National Case Reporting System and other means), analyzed, and disseminated widely.
- Cultural differences seem to play into different states' laws regarding (and level of tolerance for) corporal punishment.
- Trying to find and substantiate individual cases of maltreatment is (according to one panelist) a "failed strategy." You will always miss individual cases. It makes more sense to focus on how to make communities safer for all children.
- Areas for further research might include: (1) disaggregating child maltreatment fatalities into specific types, to better understand risk factors and patterns; and (2) evaluation research on the effectiveness of specific programs on preventing fatalities.
- At least one panelist suggested that rather than focus on getting the count and definition right, the Commission might be better served focusing on the question of *preventable* deaths.
- Although one study mentioned did not find income level to be associated with parents' self-reports of harsh punishment, research has overwhelmingly established poverty as a risk factor for maltreatment.
- Most studies have shown that race is not a factor for maltreatment once poverty and other socioeconomic variables are controlled for. The exception to this is Hispanic families, who generally have lower maltreatment rates than black or white families.
- The data is available to identify which families are most at risk. The more important question might be what to do once at-risk families are identified. Which interventions work best?

ASSESSING PRESENT AND PROSPECTIVE CHILD SAFETY: A VIEW FROM DIFFERENT SERVICE VENUES (PART 1)

This panel presented an overview of current child safety assessment and decision-making practices in several service arenas.

David Olds, Ph.D., Director, Prevention Research Center for Family and Child Health, University of Colorado

Dr. Olds is the developer of the Nurse-Family Partnership home visiting program, which is now being replicated around the country. He presented on the program's goals, results, and implementation concerns.

- Dr. Olds has been involved in prevention/early childhood work since 1970, when he worked at a child care center in inner-city Baltimore. He thought if he could get poor preschoolers off to a good start, they would have a better chance for success. But he soon came to the conclusion that interventions needed to start earlier and take into account contextual factors that compromised parents' ability to protect their children.
- The Nurse-Family Partnership program offers prenatal, infancy, and toddler in-home visiting by nurses for mothers in poverty having their first baby. It focuses on mothers in poverty because the likelihood of poor outcomes is so much higher for families living in poverty. Women in their first pregnancy are going through massive hormonal changes and restructuring of their brains. The brain is "plastic" during this period, and susceptible to adversities but also positive changes.
- The program has evidence that shows it makes a difference. One reason for this is the clarity about what the nurses are trying to accomplish and how they will go about that. The program is aligned with parents' natural instincts to protect their children.
- Nurse-Family Partnership is *not* a child abuse and neglect prevention program; it attempts to promote child and maternal health more broadly. Defining the program as focused on preventing child abuse and neglect may undermine its effectiveness by discouraging parents and communities from participating.
- Program goals include the following:
 - Improve pregnancy outcomes by improving prenatal health.
 - Help parents to provide competent care to improve child health and development.
 - Improve parents' own health and economic self-sufficiency by helping them develop a vision for their lives and make good choices in accordance with their goals and values.
- The program has been tested in three scientifically randomized controlled trials: first with a group of low-income white women in semirural New York; next with a primarily African-American urban population in Memphis, Tennessee. Most recently, they tested the effects of home visiting by nurses versus paraprofessionals delivering the same services. They found that nurses produce effects that are twice as large as and more enduring than paraprofessionals.
- Program results include significant improvements in prenatal health and reductions in children's injuries, language delays, problems of school readiness, children's behavioral problems in school, children's depression and anxiety (in middle school and early adolescence), children's substance use (into adolescence), maternal impairment due to substance use, and closely spaced pregnancies. They have also seen mothers' increased participation in the workforce and decreased dependence on welfare and food stamps.
- The program's impact on state-verified child abuse and neglect cases is most pronounced when mothers are visited during both pregnancy and during their children's infancy.

- The impact on maltreatment rates is attenuated in households where there is moderate to high levels of domestic violence. This has led to research to help program nurses address intimate partner violence more effectively.
- The Memphis trial found a significant reduction in hospitalization rates, particularly from ingestions and injuries.
- During the first 20 years of life following birth, children in the program are less likely to die from preventable causes, including sudden infant death syndrome, homicide, and injury.
- Implementation architecture is extremely important, including organizational and community capacity, nurse education and consultation, program guidelines, an information system to monitor implementation and outcomes, program assessment strategies, and continuous improvement.

Paige Rosemond, Child Protection Services Manager, Division of Child Welfare, DHS

Paige Rosemond, child protection services manager for Colorado, shared some of the state's best practices in service provision to children, youth, and families involved in Colorado's state-supervised, county-administered child welfare system.

- DHS begins assessing safety and risk upon receipt of a report. Every county has been trained on enhanced screening, which expands the scope of information sought from reporters, asks open-ended clarifying questions, and explores the family's strengths as well as needs from the reporter's perspective.
- A "RED" team then assesses whether the report meets the statutory definition of maltreatment and determines an appropriate response time. This is a team approach that considers both safety and risk. Immediate (24-hour) responses may involve present danger of moderate to severe harm. A three-day response involves impending danger of moderate to severe harm. Cases that do not pose a safety concern receive responses within five days.
- The state has increased its referrals to community resources for reports that are *not* screened in, in part through the use of flexible IV-E funding.
- Counties then assess screened-in reports using safety and risk assessment tools. These tools were revised in 2012, and training was developed through the Kempe Center. Engagement of the family throughout this process is a primary change; the new process will be implemented statewide in 2015.
- All of the recent changes are also being incorporated into the state's SACWIS system and into a proposed rule to increase consistency in practice across counties.
- Safety and risk are reassessed if there is a change in the family, prior to reunification, and prior to closing a case.
- Principles of a family service plan in Colorado include: Child safety is paramount; children belong in families; families need community support; and community partners are key to positive outcomes.
- To assess safety and risk more effectively, it is important to better support caseworkers' critical thinking and family engagement skills. This includes lowering caseloads and increasing the number of workers providing direct service, so that caseworkers have time to get to know the families on their caseloads well and can be more effective.

Kathryn Wells, M.D., Child Abuse Pediatrician; Medical Director, Denver Health Clinic at the Family Crisis Center

Dr. Wells spoke to the Commission about preventing child abuse and neglect in families with substance-exposed newborns.

- About 12 percent of children live with at least one parent who needs substance abuse treatment. Substance abuse is also a factor in 7 to 8 out of 10 child welfare cases.

- When a substance-addicted woman is pregnant, the pregnancy is often accidental but can be an opportunity to make a lifestyle change, because the mothers typically want a healthy baby.
- Colorado is addressing risks not only from illegal substances but also prescription drug abuse, binge drinking, and the recent legalization of marijuana. They are seeing more children exposed to accidental ingestion of marijuana, as well as more mothers admitting to marijuana use during pregnancy now that it is legal.
- Statistics of babies exposed prenatally are not reliable and likely underestimated. We do know that use declines a little during pregnancy (with the smallest decline among those who are younger) and typically rebounds by the infant's third month. Effects are variable, but there is no safe amount of drugs to use while pregnant.
- The Child Abuse Prevention and Treatment Act (CAPTA) reauthorization in 2003 requires states to have policies in place to identify these infants and address their needs. Dr. Wells has done some work to explore how to decrease barriers to identification. One step was to pass a law in Colorado protecting mothers from criminal prosecution if they admitted substance use during pregnancy to their physicians.
- Dr. Wells and her colleagues on the state methamphetamine task force developed recommendations based on five points of intervention: Prepregnancy, prenatal, birth, postnatal, and throughout childhood. Those recommendations can be found here: http://www.coloradodec.org/goopages/pages_downloadgallery/download.php?filename=23751.pdf&orig_name=sen_recommendations_final.pdf&cdpath=/filearchive/sen_recommendations_final.pdf
- Her recommendations specifically for the Commission were to address the following critical needs:
 - Better training and education for *all* professionals that touch families that have substance abuse issues, including but not limited to the child welfare, health care, and prison systems
 - Standardized policies from hospital to hospital and jurisdiction to jurisdiction regarding drug screening and treatment for pregnant mothers
 - Better information sharing between hospitals and child welfare regarding substance-exposed newborns, as well as the child welfare system's response
 - Data to help determine whether current actions are making any difference
 - Effective and available treatment

Elizabeth Collins, Advocacy and Resources Team Co-Director, Colorado Coalition Against Domestic Violence

Elizabeth Collins is a member of Colorado's Domestic Violence and Child Protective Services Coordinating Council and has participated on the state's child fatality review team. She spoke to Commissioners about the intersections of domestic violence and child maltreatment.

- Domestic violence (DV) occurs at epidemic rates: 1 in 4 women will be victimized during her lifetime. DV offenders are far more likely than nonoffenders to abuse their children, and DV is a factor in about 40 percent of child maltreatment cases.
- In 2013, DV was found to be a factor in 40 percent of Colorado's substantiated CAN fatalities, near fatalities, and egregious incidents, and 17 percent of fatalities alone (20 percent nationally).
- Providers need to know where a child lies on the spectrum of risk/severity of DV. At one extreme: Some DV offenders will purposefully kill their children to punish their partner.
- The best way to assess a child's risk in a DV situation is to evaluate the tactics of control used within the relationship and assess the offender's participation in targeted interventions and willingness to change. This analysis is enhanced through the co-location of DV advocates with child welfare.

- The caseworker’s ability to gather needed information and assess the situation is enhanced through the use of a trauma-informed approach to engaging and working with the adult victim.
- Traditional CPS interventions may not be appropriate for offender parents. These include reunification of offender parents back into families and mainstream parent education. Multidisciplinary offender observation is critical because these perpetrators are skilled at performing well under observation.
- Colorado employs universal screening for DV, co-location of DV advocates in child welfare offices, targeted referral to research-supported offender treatment strategies, and multidisciplinary monitoring.
- Recommendations:
 - Guiding principle: When there is a co-occurrence of domestic violence and child maltreatment, the safety of children and youth is enhanced through promoting adult victim safety and empowerment, holding the perpetrator accountable, and engaging in community collaboration.
 - Effective/recommended strategies include the following: Domestic Violence High Risk Team, Greenbook Initiative, Caring Dads, Kids’ Club and Moms’ Empowerment Groups, Safe and Together Model, National LINK Coalition.
 - Additional needs (beyond the existing paradigm): more caseworkers (lower caseloads); making child safety and well-being the primary concern of social institutions; resources and will to ensure child safety; and research-based, validated tools to identify children at risk for homicide.

Commissioner Discussion

Issues and questions raised by Commissioners in response to these presentations included the following:

- The Nurse-Family Partnership program sees a 22 percent “discount” in outcomes and economic returns from trial to national implementation. This may be because communities are referring only their highest risk families to the program. Nurses also need community backup, especially when parents lack a fundamental ability to protect their children (due to mental health and substance abuse issues, for example). The creation of community advisory boards has enhanced the quality of implementation and sustainability. Implementation *with fidelity* is critical.
- Community collaboration is also critical in cases of substance-abusing parents who may experience multiple relapses. In Colorado, every effort is made to have everyone “at the table”—child welfare, treatment, health care—to share information, wrap services around the family, and make the best decision possible about children’s safety in each individual situation. They have made a conscious choice to engage parents in a nonpunitive manner whenever possible.
- Once an adult victim is identified within a family, partnering with that adult victim (rather than maintaining a stance of “neutrality”) is in the best interest of the children. The number one resiliency factor for children in DV is a strong, protective relationship with a primary caregiver.

A STATE LEGISLATIVE PERSPECTIVE: WHAT THE FEDERAL GOVERNMENT CAN DO TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

Senator Linda Newell

Linda Newell is a state senator for Colorado’s District 26. She is vice chair of the Health and Human Services, Judiciary, and Joint Technology Committees, and founder and co-chair of the children’s caucus and behavioral health caucus. Her key points included the following:

- Recent progress in Colorado began in 2009, after a string of CAN deaths within the system. Reforms include: creation of the Child Welfare Training Academy, establishment of a Child Protection

Ombudsman office, launch of the state's child fatality review teams, creation of an Early Childhood Leadership Commission, and in integrated Office of Early Childhood.

- Progress for youth (including many in foster care) through diversion, removal of zero-tolerance policies in schools, and restorative justice practices have resulted in declines in recidivism (from 50 percent to 11 percent for youth in restorative justice programs).
- Colorado is forming the country's first statewide, multidisciplinary human trafficking task force, a statewide Suicide Prevention Commission, children's caucus, behavioral health caucus, and childhood obesity caucus. In general, there is a new culture of focus on children's issues.
- Recommendations/requests:
 - Intervention-focused requests: More support for kinship care programs, federal guidance regarding child protection ombudsman offices, and federal support for human trafficking prevention, with interstate and regional solutions.
 - Prevention-focused requests: Budget more dollars for prevention (vs. intervention), including programs like Nurse-Family Partnership; prioritize a more peaceful, child-centric culture; enhance access to mental health and substance abuse treatment services.
 - Support research and evidence-based data on the effects of marijuana on young, developing brains, to aid in the development of appropriate medical responses and protections for children.

Representative Jonathan Singer

Jonathan Singer represents Colorado's House District 11. Prior to his election he was a child welfare worker conducting investigations and working in juvenile delinquency/truancy court.

- The media's attention to the issue of child maltreatment fatalities, including the recent "Failed to Death" series, was instrumental to the success of the legislature's recent reforms.
- Recent reforms include: a new, statewide hotline system—calls are monitored at a state level to ensure follow-through (for example when divorced parents living in separate counties); consistent training in investigation techniques for hotline workers; and differential response.
- The legislature recently approved a bipartisan audit of the caseworker system and a workload study to explore whether workers are prepared and have the time and tools they need. The study identified a deficit of at least 574 caseworkers and 180 supervisors. The state needs help, in the form of federal matching funds, to address these identified deficits.

Follow-Up Comments to Commissioners

During follow-up discussion with Commissioners, Sen. Newell made the following final point:

- The well-being of children is a nonpartisan issue. At times, our ideas about the solution might be a little different, but most of the bills discussed during this meeting were passed with high levels of bipartisan support. Some of these reforms are "too important not to fund."

WORKING TOGETHER TO PREVENT AND INVESTIGATE CHILD ABUSE AND NEGLECT FATALITIES

This panel presented information regarding Colorado's multidisciplinary mechanisms and protocols for investigating and preventing child abuse and neglect fatalities.

Lindsey Myers, M.P.H., Injury and Violence Prevention Unit, DPHE

Lindsey Myers shared a public health perspective on Colorado's Child Fatality Prevention System, which consists of two complementary systems for child fatality review.

- The public health system looks at *all* preventable child deaths that occur in Colorado. Cases are identified through death certificates and include accidental deaths, deaths of “unknown manner,” suicide, and homicide, in addition to child maltreatment deaths.
- The state averages 650-700 child fatalities per year; this team reviews 200-300 of these. From 2008 through 2012, 230 deaths were identified as being the result of child abuse and neglect. The public health definition is currently different from the DHS definition, but they have been asked to reconcile the two.
- Public health uses the National Center for Child Death Review’s definition and case reporting system.
- Senate Bill 13-255, passed recently, will bring about improvements to the child fatality review process. It codifies cooperation between public health and DHS into statute and requires them to issue joint recommendations.
- Local review teams are now mandated across the state, with the onus on public health to develop this process. There are now 48 such teams, and funding for state staff and training for local teams.

Marc J. Mackert, Ph.D., Director, Administrative Review Division, DHS

The Administrative Review Division (ARD) is an independent review body for the child welfare system and conducts 11,000 reviews per year, including cases involving children in out-of-home placements, families receiving in-home services, and appeals of substantiation decisions, as well as child fatality reviews.

- Colorado’s Child Fatality Review Team is authorized in statute. It is a diverse, multidisciplinary group with 20 members, some of whom are explicitly required by statute to participate. The goal is to take a systemic look rather than to assign blame, and to identify both barriers and strengths.
- All county departments that were engaged with the family prior to the fatality provide input.
- The state requires an annual report, which provides an opportunity to look at aggregate data, identify larger lessons learned, and make recommendations.
- The child fatality review process is viewed as part of a larger continuous quality improvement (CQI) framework to inform systemic change. ARD tracks the implementation of all recommendations coming out of individual reports and the annual report.
- There are strict time frames for each step of the review process, starting with the county notifying the state DHS within 24 hours of any fatal, near fatal, or egregious incident that is suspected to be related to child abuse and neglect. The only permissible reason for delay is if releasing the information on the public-facing website would interfere with an open criminal investigation.

***El Paso County Commissioner Sallie Clark, Not One More Child Coalition
Dan May, District Attorney, Fourth Judicial District***

Sallie Clark is an El Paso County Commissioner and liaison to the DHS Advisory Committee. She also serves on Colorado Counties, Inc., Health and Human Services Steering Committee, and as vice president of the National Association of Counties. She and District Attorney May started the Not One More Child Coalition after the county experienced 10 child abuse and neglect fatalities in 2011.

- Of the 10 fatalities in 2011, four were between 1 and 5 years old, seven were from abusive head trauma, and seven involved military families. The majority had no prior contact with DHS. The children had not been seen by pediatricians; families were using emergency rooms for medical care. These became the coalition’s areas of focus.
- The coalition has been very successful: There were only three fatalities in 2012 and four in 2013. Most of the children who have died since 2011 were not born in the county, so their families did not receive the benefit of new hospital-based programs.

- The coalition includes DHS, the DA’s office, law enforcement, public health, military, hospitals, nonprofits, the media, first responders, fire departments, and the faith-based community. They are broken into seven task groups: communications, data, faith-based, first responders, hotline, medical community, and military families. There is a significant focus on public awareness and education.
- Their recommendations as they apply to the national level include the following:
 - Title IV-E waiver funds are important for providing family support services and prevention. The Social Services Block Grant also provides critical flexibility to tailor services to local needs.
 - The Second Chance Act and My Brother’s Keeper were mentioned as other programs that support communities in being proactive instead of reactive.
 - Recommendation: Bring El Paso County’s programs for military families to scale, so that soldiers and their spouses have access to these programs no matter where they are stationed.
 - Measure hospital-based programs by outcomes, rather than by how many families were reached.

Keith Brown, Law Enforcement Liaison, El Paso County Human Services

Keith Brown is a field investigator for El Paso County DHS. He has a background in law enforcement, both military and civilian, serves as the liaison for the law enforcement agencies with the county.

- DHS created this position about five years ago to bridge the gap between child welfare and law enforcement. It has been challenging.
- The department has a strong relationship with law enforcement in Colorado Springs—Officer Brown is co-located in that agency and can access the law enforcement records management system to cross-reference domestic violence and child abuse and neglect cases with the child welfare database.
- Other departments have been more difficult. Challenges include lack of notification about cases and a reluctance to engage in joint investigation processes. Access to National Crime Information Center records for background checks is another issue, particularly when new adults enter the home.
- Recommendation: A national child protection database where professionals can access child welfare records from other states in a more timely way, to better inform decisions about children’s care.

Karen Logan, Child Welfare Manager and Child Protection Manager, El Paso County

Karen Logan further elaborated on the challenges El Paso County DHS has experienced in attempting to connect and coordinate with law enforcement agencies.

- A turning point in that relationship was the introduction of Domestic Violence Enhanced Response Team (DVERT), a grant program to work with families that had the highest incidence of domestic violence. That collaboration opened communication with law enforcement agencies and family advocates, leading to a joint response to specific cases of domestic violence in the county.
- The DVERT grant has expired, but the county has continued to pursue this type of collaboration on domestic violence and felony child abuse cases. It has been particularly successful in Colorado Springs, where they have created a felony response team with specially trained CPS and law enforcement staff. They conduct joint meetings, trainings, and case reviews, and response teams are available 24/7.
- Child welfare caseworkers are not just about intervention—only about 10 percent of assessments end up as open cases. The other 90 percent of cases are opportunities to do prevention work and talk about child safety.

Laura Rago, Chief Deputy County Attorney, El Paso County Attorney's Office

Rago's office provides legal representation for the 10 percent of cases that become court-involved. They represent DHS, and 100 percent of their caseload is abuse and neglect cases. She discussed the legal process and considerations in child abuse and neglect fatality cases.

- The goal is to be in and out of families' lives in 18 months; 1 year for children under age 6.
- At the adjudication phase (deciding whether DHS should remain involved), the burden of proof is a "preponderance of the evidence"; to terminate parental rights, "clear and convincing evidence" is required. Both of these are lower than the criminal standard.
- As soon as DHS identifies "imminent risk," they consult the county attorney. Attorneys are on call 24/7 to discuss safety plans and legal basis to open a case.
- With fatalities, the concern is often for immediate custody/safety of surviving siblings and protective orders. Fatality criminal cases and dependency cases for surviving siblings are seen by the same judge and tracked together to ensure consistent orders, etc.

Jill Nugin, Family Advocacy Program Manager, Army Community Service, Fort Carson Army Base

Jill Nugin manages all programs addressing spousal and child abuse on Fort Carson. She affirmed that much of what was said by researchers earlier in the meeting has been borne out by her own experience in working with families. Military families on base are often young, struggling financially, and socially isolated.

- Many of the fatalities in El Paso County in 2011 were at the hands of a male caregiver (father or boyfriend) who was not equipped to deal with an infant that wouldn't stop crying. They looked specifically for programs to help this target population. Programs like Boot Camp for New Dads and training mentor dads could help military families across the country with similar populations.
- They also work with soldiers during reintegration training, talking about reintegration with the family and expectations for children's different developmental stages.
- The Nurturing Parenting program is an evidence-based 12- to 16-week program that focuses on parental empathy and clear developmental expectations.
- They have seen significant decreases in the number of child abuse cases at Fort Carson.
- Two recommendations: Make programs like these consistently available at all installations, and remind people that funding the Department of Defense means funding programs like these that protect and support soldiers and their families.

Commissioner Discussion

Issues and questions raised by Commissioners in response to these presentations included the following:

- Family advocacy programs are required to have memorandums of agreement with states to share information and work together on child abuse and neglect cases involving military families. El Paso County places a high value on this collaboration; this may not be the case in all jurisdictions.
- State and local review processes are an opportunity to look at all systems that had contact with a child and family prior to a fatality. In practice, there are sometimes concerns about confidentiality that arise and prevent sharing of information (particularly around domestic violence).
- DHS has been criticized for working closely with law enforcement; some people are concerned about criminalization of families. But DHS has found that joint investigations better position them to support the nonoffending parent and get services to the family more quickly.
- The DA's office works closely with law enforcement, including conducting joint trainings, but does not have a formal MOU with them.

- In a county-run, state-supervised system like Colorado, the state provides considerable support, training, and standards. However, counties have unique demographics and dynamics that need to be taken into account.

COLORADO'S STRATEGIES FOR PREVENTION OF CHILD ABUSE AND NEGLECT FATALITIES FOR CHILDREN NOT KNOWN TO THE CHILD WELFARE SYSTEM

This panel explored Colorado's strategies for prevention and early intervention with at-risk families *before* any child abuse or neglect is evident or suspected.

Kendra Dunn, Child Maltreatment Prevention Director at the Office of Early Childhood within DHS

Kendra Dunn provided Commissioners with insight into Colorado's work to consolidate prevention efforts within a single unit. This unit braids federal Promoting Safe and Stable Families and CAPTA Community-Based Child Abuse Prevention (CBCAP) funding with state funding that flows into the state's Children's Trust Fund via a fee on divorce docket filings and from the Governor's 2.0 plan. The latter funds a pilot Colorado Community Response Program that provides critical flexible funding to help families in alleviating stressors. Dunn offered three specific recommendations:

- Ensure supports are available where families already are. In particular, she suggested the Commissioners look at evidence-based programs such as Healthy Steps, which is implemented in pediatric health care settings and is augmented by home visits. She cited the program's cost-effectiveness and its ability to promote and facilitate a child's access to health care.
- Recognize that many young children are cared for by friends, family members, or neighbors, and those community members need support and education.
- Do more than just fund effective programs. She suggested looking at the prevention spectrum designed by the Oakland-area Prevention Institute. In addition to direct services to families, there needs to be a focus on and funding for strategies that are working to change community norms and environments and promote collaboration across systems.

Mark Kling, Executive Director of the Family Resource Center Association

The Family Resource Center Association offers comprehensive, coordinated prevention services to families in 24 locations throughout the state of Colorado, through evidence-based programs and a dual-generation approach. Kling's recommendations to the Commission included the following:

- Provide more support to entities and programs that implement comprehensive, coordinated, dual-generation preventive approaches. They have found these services to be effective and cost-effective.
- Encourage investment in evidence- and research-based programs with outcomes that are analyzed and verified by an objective third party.
- Focus resources on prevention, including some funding to support the infrastructure of organizations that operate proven-effective programs and models.
- Incentivize collaboration by having a pool of funding available to support like-minded prevention-based providers who work together.

Linda Mikow, Forensic Interviewer at Ralston House

Linda Mikow is a forensic interviewer at Ralston House, a children's advocacy center (CAC). CACs are child-friendly places where multidisciplinary stakeholders (e.g., law enforcement, CPS, health care, victim services) come together to coordinate trauma-informed responses for children who have been abused. The forensic interview is done by a specially trained professional who can ask nonleading, open-ended questions.

Mikow testified regarding the importance of having children who have witnessed domestic violence be brought to a CAC for a forensic interview. It is sometimes difficult to convince law enforcement to view children as witnesses and invest the time in these interviews, but Mikow argued that communities must invest this time so that children can be heard, their needs identified, and future fatalities prevented.

Donna Parrish, Assistant Professor of Pediatrics, School of Medicine; Associate Director of Diversity and Inclusion, Kempe Center

Donna Parrish provided the Commission with greater detail about the interplay of race and child abuse fatalities. She noted that approximately 85 percent of victims of child fatalities are either white (38 percent), African-American (31 percent), and or Hispanic (15 percent). However, when those numbers are placed in the context of population data, Pacific Islanders and African-Americans experience the highest rates of child fatalities. Her recommendations emphasized the importance of addressing this issue with a race equity lens and included the following:

- The research agenda should include a focus on resiliency and strengths. It also is critical that there be a multidimensional look not just at low-income populations, but other families as well.
- Sameness does not equal fairness. The same services will not have the same effect on all populations, and efforts must be made to bridge the cultural divides.
- Existing prevention strategies must increase the rigor of their cultural responsiveness. It is important to engage cultural brokers in programs such as home visiting, so that services are delivered and outcomes observed from a culturally proficient perspective.

Grace Sage Musser, Clinical Services Director, Denver Indian Family Resource Center

Grace Sage Musser spoke to the economic and psychological challenges that American Indians and Alaska Natives in urban settings face. In addition, these families face historical trauma from when they were removed from reservations and relocated to cities, such as loss of identity and family support structures. Musser echoed the previous presentation, arguing that the child welfare system does not accurately classify the race of children and families. She noted that without an intentional effort to be more accurate in classifying the race of the children and families, it will be difficult to undertake deep analysis of outcomes and to gather data to inform prevention and intervention strategies. Alaska Native and American Indian families encounter unique hurdles to finding, accessing, and utilizing services because not all families have the skill set needed to navigate systems and services. Her recommendations included the following:

- Build relationships and trust by engaging in meaningful dialogue with the community.
- Develop a shared understanding of strengths as well as challenges. Ask: “What is working, and how can we make that even better?”
- Develop both immediate and long-term strategies.

Commissioner Discussion

Issues and questions raised by Commissioners in response to these presentations included the following:

- Panelists were asked to suggest specific programs or services that focus on culture and have demonstrated a reduction in child abuse and neglect fatalities. Recommendations included the Healthy Black Babies Program, Healthy Families Program, and Life Skills Program.
- The discussion then turned to definitions, application, and community readiness with regard to evidence-based programs and practices, with a particular focus on the implications for tribal communities. Panelists mentioned the importance of training in cultural competence and strength-based approaches.

- Dual-generation programs are those in which both the parent and child are served at the same time (for example, the Nurturing Parenting Program has concurrent curricula for children and parents). These programs attempt to address the issues at hand while also promoting overall family stability and building a foundation of health, safety, and well-being for children as they grow into adults.
- In child death reviews, it is important to get beyond the taboo of race and look at a child's life and death with a culture and race lens. Strengthening parental capacity requires ensuring that appropriate services are available and that the family can navigate them.

COLORADO'S STRATEGIES FOR PREVENTION OF CHILD ABUSE AND NEGLECT FATALITIES FOR CHILDREN KNOWN TO THE CHILD WELFARE SYSTEM

The final panel of the day was focused on Colorado's strategies for identifying families with an elevated risk of child and abuse neglect fatality and providing effective interventions to reduce risk.

Paige Rosemond, Child Protection Services Manager, DHS

Paige Rosemond began by revisiting her earlier presentation about the state's work to validate new safety and risk assessment tools. She noted that predicting human behavior is challenging and pointed out that tools can never fully replace the role of informed judgment, ongoing training, and comprehensive and rigorous support services for families. Other key points included the following:

- Although the state is working to track data and explore trends through its child fatality review process, fatalities provide a small sample size, which impacts the ability to generalize from findings.
- It is difficult to compare statistics and trends in Colorado with those in other states because of the variation in definitions of child abuse and neglect.
- Flexible funding is needed to promote further collaboration between government and the community to prevent child welfare involvement and maintain children safely in their own homes.

Stephanie Villafuerte, Executive Director, Rocky Mountain Children's Law Center

Stephanie Villafuerte is a former criminal prosecutor and current member of the DHS Child Fatality Review Board. She provided Commissioners with three specific recommendations:

- **Create an independent child medical examiner (ME) system.** CAPTA should be amended to require states to employ a chief ME with expertise in forensic pathology and child abuse deaths to review all child death cases. Currently, at least half of states and many counties have an elected coroner instead of an ME. A coroner is not required to have a medical degree or background and may lack the highly specialized experience and training needed to make accurate findings in child fatality cases.
- **Mandate autopsies for all deaths of children within a certain age range.** Only half of states currently have such a law. Autopsies are needed to more accurately establish the cause of death and provide a database for research and education.
- **Amend CAPTA to require Birth Match.** Mothers who have pending child welfare cases or previous terminations of parental rights frequently give birth to new children in new hospitals and jurisdictions; these births must be tracked so that appropriate services can be provided.

Judge Kathy Delgado, Colorado 17th Judicial District Court

Judge Delgado's presentation included the following key points:

- Colorado has Best Practice Court Teams in every judicial district. These include representatives from social services, law enforcement, education, medicine, and substance abuse treatment, as well as respondent parent counsel, guardians ad litem, and CASAs. Some of the best teams include mentor parents who have previously been involved with the dependency and neglect system.

- It is important to understand that juvenile courts are not “kiddy courts.” Juvenile judges must be well trained, passionate, and committed. Collaboration with Casey Family Programs has aided in the formation of a Judicial Permanency Advisory Group working to reduce congregate care and enhance judicial leadership skills.
- Time must be allotted during hearings to develop individualized treatment plans with families.
- The “one family, one judge” approach is one way to ensure that a family intersecting with various courts (criminal, juvenile, and family) has a judge who can address their needs appropriately.
- It is important to hear children’s voices whenever possible; children will tell you things about what is happening in their homes and foster homes that may not otherwise be discovered by professionals.

Kathryn Wells, M.D., Child Abuse Pediatrician; Medical Director, Denver Health Clinic at the Family Crisis Center

As a child abuse pediatrician, Dr. Wells works on the front lines of investigations alongside law enforcement and CPS. She made recommendations about the various roles that health care providers play in working to protect children and prevent fatalities:

- **Identifying and reporting suspected child abuse.** Medical practitioners need training to identify child abuse as part of their standard curriculum. Training is also needed regarding when and how to report child abuse to authorities.
- **Information sharing.** Mandated reporters need assurance that they will receive information in response to their report, so they know the outcome and have a better idea of how to respond the next time they see that child or family. Confidentiality is important, but we need to find ways to get past HIPAA requirements in these situations, as we have done with FERPA (Family Educational Rights and Privacy Act) rules.
- **Involvement of medical personnel in child welfare investigations.** There are currently no standards for when a medical professional is to be engaged during the course of investigating child abuse. Two things that make this difficult are the number of demands on child welfare workers’ time and the lack of available training for medical professionals. Dr. Wells recommended developing regional networks of trained providers, as well as a state Child Welfare Medical Director to provide oversight.

Commissioner Discussion

Issues and questions raised by Commissioners in response to these presentations included the following:

- Courts require background checks on any adult in the home and may require a new safety or risk assessment when circumstances change, including a new person in the home.
- Child protection officials have the ability to appeal a decision to a higher court, for example if they think it is not in the best interest of a child to return home. The courts have worked to expedite such appeals, which are rare.
- Upon further questioning, Ms. Villafuerte suggested the establishment of a statewide medical examiner, with a second tier of MEs at the regional level, as well as a second-tier system of regional MEs or specially trained physicians.
- Mandated reporters should have some responsibility and accountability for maintaining their competency as reporters. Required training might be woven into professional education, such as through schools of law, medicine, education, and social work.
- Some of the things that interfere with the timeliness of child fatality reviews include pending criminal prosecutions and delayed determinations or reports from coroners and MEs.

- Questions were raised about the independence of fatality reviews that take place within DHS and DPHE. The placement of reviews within the state's ARD has provided some additional independence of reviews within DHS.
- Promising practices such as the ones taking place in El Paso County are disseminated to other counties via Colorado's Promising Practices Workgroup, which works to validate practice and promote its replication. Although it is ultimately each individual county's decision whether to adopt a particular practice, the state plays a role through rule, policy, and training.
- Court practices were explored further, with a focus on how delays in criminal court proceedings may impact decision-making in civil and family court. Judge Delgado noted that part of the solution lies in training (including on trauma-informed courtrooms) and reducing how often judges rotate in and out of juvenile/dependency courts. The timing of law enforcement investigations often does not support the stricter CPS investigation timelines.
- It is important to hear from as many people as possible about the birth family's progress, including foster and kinship caregivers, CASA volunteers, and the children and families themselves.

Closing Remarks

Chairman Sanders thanked presenters and attendees (in person and by phone and webinar). The Commission planned to reconvene the next morning at 8:00 for an Executive Session, and as a full body at 8:30.

The meeting adjourned for the day at 5:00 p.m.

TUESDAY, SEPTEMBER 23, 2014

Day 2 of the meeting was open to the public, although the agenda consisted almost entirely of Commissioners' deliberations. The public was welcome to observe by phone, webinar, or in person.

OPENING REMARKS

Reggie Bicha, Executive Director, DHS; President, Board of Directors, APHSA

In Colorado, the focus is on connecting prevention with intervention, redesigning the entire front end of the child protection system, and expanding transparency and accountability—all part of the governor's child welfare plan. Colorado exceeds current CAPTA requirements and is one of only two states in the country to require reporting and review of egregious incidents and near fatalities.

Bicha's recommendations to the Commission included the following:

- Add more on-the-job, applied training for caseworkers. Classroom learning is not enough. Caseworkers need field experience and coaching. Colorado's training academy is currently piloting such an effort.
- Provide federal funding to modernize SACWIS technology to deliver the information needed to keep children safe. The current SACWIS technology is 1980s vintage.
- Revise quality improvement systems and Child and Family Services Review (CFSR) requirements to better monitor the actual practice of child welfare. It is important to observe practice beyond what is included in the case notes.
- Diversify the workforce. Even the best-trained and best-supervised social workers do not have all the expertise children in the system need. Every child deserves a multidisciplinary team.
- Make federal finance reform a priority. The time for federal waivers is past. It is time to support federal funding that supports all states to provide the right services to children at the right time.

Commissioner Discussion

Commissioner questions and comments led to the following points:

- Colorado has a program called C-Stat that captures information about kids and families served; they are now looking at how to incorporate predictive analytics into their work to better protect children and prevent fatalities.
- Children and families should not have to experience abuse or neglect to get help. The state has created an integrated Office of Early Childhood and is working to better connect prevention with intervention through programs like Nurse-Family Partnership, SafeCare Colorado, and a community response program.
- Multidisciplinary teams can identify risk factors that a single caseworker may miss. This can make a crucial difference in getting support for the family and also provide the additional information judges need to make better decisions.
- Federal and state governments share a responsibility for children's safety, but they have different roles and expectations. Bicha wants the federal government to challenge states to do a better job and provide supports and resources for more innovative solutions. There is a growing consensus for title IV-E reform to better connect funding to the priorities and needs of children and families.
- Bicha suggests creating funds for states and possibly academic institutions to implement practice audits. He used the analogy of a surgeon who learns new technology but never tries it on a patient and suggests that this is what happens with child welfare workers.
- Should standards of best practice go beyond the "checked-box" process of quality improvement? Bicha noted that there is a role for checklists, but they should be meaningful, thoughtful tools to help workers slow down and analyze their practice. It is also important to look beyond checklists.

CASE REVIEWS

Commissioners Rubin and Petit presented several cases for discussion. These cases will be available on the Commission's website: <https://eliminatechildabusefatalities.sites.usa.gov/event/denver-colorado-public-meeting/>

Commissioner Petit presented a true case of a child's death that illustrates the conflict between civil and criminal proceedings and the different standards of evidence and truth required by each. The laws were there to protect the child, but the child was not removed from the perpetrator and she was killed.

Commissioner Rubin presented several hypothetical cases—the same child in different scenarios and with different outcomes, all types of cases he has seen as a pediatrician. His cases illustrated the role of the health care system. Health care reform has focused on quality of care, but there has been little discussion about child protection, an opportunity for the Commission.

Commissioners raised the following issues and questions:

- When there is both a child protection and criminal case in the same family, there should be mandated collaboration between the courts, or the case should come before one judge.
- In Wisconsin, there are 10 factors to identify "hot-button cases"; a multidisciplinary team reviews those cases monthly. The Commission should include recommendations applying to hot-button cases.
- Due process for parents must still be kept in mind. We cannot make presumptions about one case based on the experience of a past case in the same family.
- How can we expedite court hearings in hot-button cases? What about going outside of the formal court process altogether for some cases?

- Ask every presenter in future hearings to answer the question: What do you do when you have a hot-button case?
- The vast majority of children in the CPS system are born into Medicaid. Our current system uses adult health standards for children's issues. There is currently no surveillance system that looks directly at Medicaid claims to identify children with serious injuries in the first year of life. What would a health information exchange system look like for children?
- What is the role for federal mandates in terms of making referrals in high-risk medical cases? Could there be incentives and bonuses to hospitals and pediatricians?
- Medicaid could use its Quality Measures Program to establish incentives for medical providers to follow up with children at risk to help ensure that they do not fall through the cracks. If Medicaid changes its policies in this way, commercial payers may follow.
- Some large jurisdictions are adding medical units within their CPS agency.
- What is the capacity of the child welfare system to respond to increased reports that could result from some of these suggestions?
- What is the role of the community in identifying and supporting children in hot-button cases? Of mental health and education?
- Community responses cannot always be put into an evidence-based framework. It is more complex than that.

COMMISSIONER EXPERIENCE

Next, Chairman Sanders asked the Commissioners to provide a few words about their background and areas where they felt they could best contribute to the Commission's work.

- **Commissioner Ayoub brings life experience as a survivor of human trafficking, as well as her communication expertise.** She pointed out that there are many crossovers between trafficking and child fatalities, including the level of violence involved, as well as issues such as familial trafficking, the use of children of trafficking victims as tools for control, and the need for more trauma-informed practice and training. In terms of communication, Commissioner Ayoub cautioned her colleagues to be aware that the terms being used in hearings may not be understood by all present, or may not be understood by everyone in the same way. Clarity and simplicity are important. Commissioner Ayoub also emphasized the importance of narrative and repetition. She asked the Commission staff to look into the use of social media to increase outreach.
- **Commissioner Zimmerman is a tribal social worker with expertise in childhood trauma and intergenerational/historical trauma.** She urged the Commission to remember that there are 566 federally recognized tribes, all with unique systems. Most tribes do not receive CAPTA funding, and in many cases data systems do not exist. Systems and jurisdictional issues are incredibly complicated. Commissioner Zimmerman argued that the Commission needs to hear from agencies and groups such as the Bureau of Indian Affairs, the Indian Health Service, National Indian Health Board, and the Native American Rehabilitation Association.
- **Commissioner Covington has a public health background and 20 years of experience studying how and why children die.** She has expertise in the various types of deaths and, in particular, how child death review processes function in each state. Commissioner Covington also has studied the issues involved with the various national systems that currently measure child abuse and neglect.
- **Chairman Sanders is a former child welfare director in a large jurisdiction that experienced a large number of fatalities with a lot of media attention.** He was a child welfare director for nearly 14 years and now works with states and on public policy through Casey Family Programs. Chairman Sanders is familiar with many aspects of child welfare financing, including titles IV-E and XX. Based

on that experience, he shared that federal policy will be one mechanism for change, but the Commission will also need to think about how federal policy translates into on-the-ground practice.

- **Commissioner Dreyfus began her career in county government and has been in charge of child welfare in two different states (Wisconsin and Washington).** From that experience, she shared her concern that policymakers have not kept up with the complexity of issues faced by kids and families in the child welfare system today. She is interested in moving the system more “to the front end,” diverting more children and families from the system earlier in the process. She also has extensive experience with state title IV-E training systems and SACWIS systems and has a keen interest in building cross-system interfaces. In her current work, she emphasizes the importance of the “third sector,” nonprofit human services.
- **Commissioner Bevan has done postdoctoral work in research and has 20 years of experience translating research into policy in the U.S. Congress.** She has extensive expertise in federal law and sees significant disconnects between the laws and their implementation. She also is an expert in federal funding streams and committees of jurisdiction.
- **Commissioner Martin is a former public defender and now serves as Presiding Judge for the Child Protection Division in Cooke County, Illinois.** Judge Martin has an abiding interest in what happens to children when they leave the court. She suggested that there needs to be more emphasis on the goal of child and family well-being. The state is not a good parent for children; all children need a loving family. Commissioner Martin also emphasized the importance of asking families what *they* think is best and trying to help them get that for their children. She has completed considerable training through the National Council of Juvenile and Family Court Judges on the overrepresentation of minorities in child welfare, implicit biases, and issues of permanency for older youth. She also is concerned about building awareness around the issues of trauma, human trafficking, and immigration.
- **Commissioner Petit is a longtime community organizer who now runs the Every Child Matters Education Fund.** He provided some of the history of how, through community organizing, a coalition was able to get the Protect Our Kids Act passed and this Commission funded. Commissioner Petit’s focus is on systems and the related questions of safety nets, distribution of resources, and what our culture values.
- **Commissioner Rodriguez brings her personal experience of being one of the “hot-button” cases as a youth in the child welfare system; she is currently a lawyer and executive director of the Youth Law Center, which is dedicated to changing the child welfare system to be more responsive to children.** She shared with fellow Commissioners the deep responsibility she feels to protect the children who *are* known to the child protection system and, in particular, sexually exploited youth in group or institutional care. Many of these youth commit suicide, although their deaths are not “counted” as being a result of abuse or neglect. A third focus for Commissioner Rodriguez is offering preventive services to youth who grew up in foster care and who are now parents themselves.
- **Commissioner Rubin is a pediatrician with extensive background in the population health model.** He works in a practice in which 30 to 35 percent of his patients receive health insurance through the Medicaid program. Dr. Rubin has extensive case experience diagnosing child abuse, which has led to an interest in the connections among child- and family-serving systems (including child welfare, Medicaid, hospitals, pediatricians, behavioral health, juvenile justice, and the schools). He also has conducted research in the areas of kinship care and the overuse of psychotropic medications in foster care. He is a co-founder of the Policy Lab at Children’s Hospital of Philadelphia, a multidisciplinary center exploring how research can better inform policy and practice. Recent research has included evaluation of home visiting programs and studying the elevation of risk among military families during postdeployment periods.

SUBCOMMITTEES

Commissioners reflected on early lessons learned through state hearings and public testimony. They agreed that the Commission would be well served by establishing subcommittees. Several themes emerged regarding the role of and scope of work for subcommittees:

- The Commission needs to draw on the experience and expertise of prior task forces and commissions, as well as federal agencies leading the way on these issues (e.g., U.S. Department of Health and Human Services [HHS], CDC, National Institutes of Health [NIH]).
- The Commission aims to be intentional across subcommittees about the approaches taken, words spoken, and recommendations made with regard to race, equity, and culture.

After significant discussion, the following six subcommittees were established, and Commissioners were identified to lead the work of each one. The scope of work also was discussed for each subcommittee in a preliminary way, with the understanding that significant areas of overlap are likely and the process should remain fluid. Subcommittees will be asked to report back to the full Commission with a fuller delineation of their scope of work. The following subcommittees were established:

- **Measurement and counting (Commissioner Covington).** Areas of focus include:
 - Why do we count and what do we count?
 - How effectively existing data sources and systems capture child abuse and neglect fatalities
 - Costs associated with existing data systems
 - Role of surveillance and data beyond the child welfare system
 - Opportunities to enhance existing data sources and systems
 - Who makes the determination about the cause and manner of a child's death and the type of education and training these professionals need
 - Quality, structure, and accountability of local and state-level fatality reviews
 - Examination of data sources/systems for near fatalities
- **Children *known* to the child welfare system (Commissioners Petit and Rodriguez)**
 - Determining what "known" means within current NCANDS data, and whether this data is sufficiently instructive as to a child/family's prior contact with the child welfare system(s)
 - Degree to which multidisciplinary teams are jointly informed, planning, sharing information, and providing for interventions in "hot button cases"
 - Examination of CPS training, including before a caseworker handles a case in the field, and the size of caseloads
 - The role of the courts and model court practices
 - Translating fatality review team recommendations into policy and practice change
- **Children *not known* to the child welfare system: A public health and upstream prevention lens (Commissioners Dreyfus and Rubin)**
 - The public health approach: recognizing the varied touch points where systems intersect with a child and family (e.g., home visiting, WIC, health care, early intervention)
 - Harnessing health care quality measures and Medicaid to aid in the identification and tracking of risk indicators
 - How access to safe and affordable child care impacts prevalence of child maltreatment fatalities
 - Multidisciplinary and reciprocal information sharing
 - Examination and understanding of near fatalities
 - Translating fatality review team recommendations into policy and practice change

- Analysis and recommendations about prevention and intervention strategies that are supported by evidence or research
- **Military (Commissioners Rubin and Covington)**
 - Understanding the military's unique structural elements (e.g., policies, practices, and resources)
 - Challenges with collaboration and information sharing
 - Role of structured decision-making—could what is being learned and utilized by the Department of Defense be utilized more widely?
 - Responding to the specialized needs of returning veterans and the effects of post-traumatic stress disorder (PTSD)
 - Possibility of jointly convening the National Association of Public Child Welfare Administrators and the military to advance shared testimony and recommendations
- **American Indian/Alaska Native Child Welfare (Commissioners Zimmerman and Martin)**
 - How issues that cut across populations exist and are enhanced in this unique population (e.g., identifying risk, team approaches, information sharing and confidentiality, caseloads)
 - The degree to which current data sources/systems do not capture the experiences of American Indian/Alaska Native children
 - Infrastructure issues, including data and service delivery
 - How funding limitations impact prevention and intervention strategies.
- **Public Policy (Commissioners Bevan, Cramer, and Horn)**
 - How to weave key issues (e.g., data, team approaches, confidentiality and information sharing, risk factors, caseloads, evidence about what works) across all subcommittee work
 - The quality, structure, and accountability of citizen review panels (CRPs) and the similarities/differences with local and state-level fatality review teams
 - Ways to leverage knowledge, leadership, and funding of federal agencies (e.g., CDC, National Institutes of Health, U.S. Department of Health and Human Services, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration)
 - The extent of states' current compliance with CAPTA
 - Relevant federal policy, practice, and budgets, as well as state-level decision-making on the Commission's work

Although a communications subcommittee was not officially established, Commissioner Ayoub will work directly with staff on communication efforts.

The meeting adjourned at 2:30 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.



David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities

12/22/14

Date