



COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

VERMONT PUBLIC MEETING HIGHLIGHTS—OCTOBER 23-24, 2014

The Commission to Eliminate Child Abuse and Neglect Fatalities held a public meeting at the Sheraton Burlington in Vermont on October 23-24, 2014. The purpose of the first day of this meeting was to explore child abuse and neglect (CAN) fatalities in Indian Country, the state of the art of safety assessment in public child welfare and related human service arenas, how the study of near fatalities may aid in fatality prevention, and Vermont's public health strategies for preventing CAN fatalities. On the second day, the Commissioners deliberated on the topics of counting and confidentiality. More than 125 people attended via teleconference or in person. This brief provides highlights from the meeting, including key points on the following:

- CAN fatalities in Indian Country
- Assessing risk
- Assessing safety
- Near fatalities
- Vermont's public health approach
- Commissioner deliberations

The meeting opened with a presentation by a Vermont foster and adoptive parent, Tammy Simoneau. Simoneau has cared for many children with special needs, including several whose brains have been severely injured due to shaking. She expressed concern about the lack of education in the child welfare system—among staff as well as biological parents—about proper care for children with special needs. She argued that the expectations for what biological parents need to understand and achieve before being reunified with their children are not high enough. In these cases, she indicated that parents should have to have knowledge about how to best address and cope with their children's needs, development, and care. She believes that future fatalities may be prevented through better flagging of at-risk families and children, increased utilization of the Adoption and Safe Families Act (ASFA) bypass of reasonable efforts, smaller child welfare agency caseloads, increased training for caseworkers, and consultation with foster parents as experts in planning for children's long-term safety and care.

CAN FATALITIES IN INDIAN COUNTRY

Terry Cross, founder and executive director of the National Indian Child Welfare Association (NICWA), provided Commissioners with an overview of the historical and cultural context in which tribes are addressing CAN, the current status of data, jurisdictional issues, policy and funding challenges for tribes, and ways that tribes are addressing these issues (including collaborative efforts with states). Cross prefaced his comments by establishing the vast diversity within Indian Country in terms of tribes' size, economics, and government structures and giving a brief history of the legacy of trauma and cultural genocide with which tribes continue to struggle.

Quality data currently does not exist for the number of American Indian/Alaska Native (AI/AN) children who die from CAN or the specific risk factors for fatality among this population. Tribes have no

mechanism for reporting to the National Child Abuse and Neglect Data System (NCANDS) database. NICWA conducted a study several years ago to show how such a mechanism could be created, but nothing has yet been done with the findings. Available data suggest that community risk factors include a high concentration of poverty, low access to services, high rates of criminal victimization, and lack of police protection—factors that Cross argued indicate the need for a public health response to protect AI/AN families. Data also suggest that AI/AN children are vastly overrepresented in out-of-home care and that, in general, neglect rates are higher but abuse rates lower than for the general population. Cross believes this is because cultural beliefs about the value of children to society mitigate risk.

Because of the “checkerboard” nature of Indian land ownership, it can be difficult to determine who has jurisdiction in a particular case. These cases are further complicated because definitions in the federal Indian Child Welfare Act (ICWA) differ from Child Abuse Prevention and Treatment Act (CAPTA) definitions, and state and tribal codes differ. Cultural factors often come into play when defining neglect; for example, Cross cited a case in which a state attempted to remove children from their community because the family lacked resources to heat their home.

Cross argued for the establishment of local teams and intergovernmental agreements to ensure adequate child protection, claiming efforts are most successful where these agreements are in place. NICWA is currently working with tribes to develop in-home systems of care to help tribes define child safety and keep children safely within their families and communities. Community-based approaches can help reduce removal of children from their villages. Training to build capacity also is necessary. To achieve these goals, Cross said, tribes need access to federal child welfare funding—many still do not have access to funds under titles IV-E and IV-B.

THE CHILD WELFARE SYSTEM’S ROLE IN ASSESSING RISK AND PREVENTING FATAL MALTREATMENT

Emily Douglas, associate professor at the Bridgewater State University School of Social Work, presented research regarding child welfare workers’ training to identify risk factors for fatal child maltreatment. A study that Douglas conducted in 2010-11 found that workers had significant gaps in their knowledge about evidence-based risk factors for CAN fatalities and that there was very little information on this topic in textbooks or the preservice curricula in 20 states. She also found that perceptions about caseworkers who experience a fatality on their caseloads (frequently portrayed by the media as young, untrained, and inexperienced) are not supported by her research.

Although no research has been conducted to link actual practice behaviors to children’s deaths, Douglas suggested that risk assessment tools are often overruled by clinical judgment. Workers may need more specific training on how to implement a strength-based approach in a way that does not jeopardize safety.

Her recommendations included the following:

- Increase training for child welfare professionals about the risk factors for fatal CAN.
- Integrate assessment for fatal CAN among all staff, across the board.
- Initiate conversations about simultaneously assessing families for risks and strengths.
- Increase research funding to better understand all of these aspects of child welfare practice. One important area for research cited is the question of whether workers are missing critical warning signs or lack the ability to adequately respond to the warning signs, once identified.

ASSESSING SAFETY IN CHILD WELFARE, LAW ENFORCEMENT, AND KEY INTERVENTION SERVICES

The next presentation consisted of a panel of speakers on the topic of safety assessment in public child welfare. The first speaker was Theresa Costello, executive director of ACTION for Child Protection. She

provided a brief overview of the history of risk and safety assessment approaches and characterized the difference between risk and safety using the following equations:

$$\text{Risk} = \text{Likelihood of maltreatment}$$

$$\text{“Unsafe” child} = \text{Threat of danger} + \text{Vulnerable child} - \text{Protective capacity of caregiver}$$

In the second equation, protective capacity is identified through a very specific assessment of the caregiver’s cognitive, behavioral, and emotional capacity. Costello indicated that safety should be assessed at specific points throughout the life of a case, including investigation, initial contact, investigation conclusion, removal or reunification, visitation, and case closure, as well as periodically for ongoing cases (in-home or out-of-home). Three primary safety assessment approaches being used in the field today are Structured Decision Making (SDM), Signs of Safety, and the SAFE model. While these approaches share many strengths, including adequate assessment of *present* danger and an increasing emphasis on family engagement, Costello also identified limitations, such as continued confusion about safety vs. risk, inadequate assessment of *impending* danger, and reunification decisions that are not always safety-based. Implementation with fidelity continues to be a challenge.

Costello argued that further research is needed in several areas, including safety model outcomes, inter-rater reliability of current safety assessment tools, construct validity, and fidelity. Finally, she noted that it is unrealistic to expect any safety assessment tool to prevent all CAN fatalities. Tools are important guides to decision-making but she suggested that it is equally important to focus on staff skills such as family engagement, effective supervision, and critical thinking.

Costello was joined on this panel by three social workers from the state of Vermont, who provided an overview of the state’s safety assessment practices. Common themes from their presentations include high caseloads and the lack of time to plan, effectively respond to, and document cases. Inadequate training for caseworkers and partner providers also was cited as a difficulty. Families on their caseloads are increasingly complex and high risk. Strategies they cited as beneficial included safety assessment tools such as SDM, multidisciplinary teams, and the ability to share families’ information among service systems in real time to support safety planning.

Their recommendations included the following:

- Create a mechanism for faster, easier information-sharing between states.
- Improve caseworker training and reduce caseloads.
- Fund proactive services that can “wrap around” families’ needs.

The subsequent panel consisted of representatives from various child welfare partners such as law enforcement, domestic violence, substance abuse, and mental health services in Vermont. Panel members provided their perspective on how these service systems assess and consider the safety of children when providing services to caregivers/parents. They suggested a number of changes to funding systems, including the need for flexibility to encourage collaboration and information-sharing among services, grants lasting for longer periods, and funding streams that pay states to achieve particular outcomes. Several panel members, including representatives of domestic violence, substance abuse, and mental health services, emphasized the interrelationship of family members’ needs and the need to assess and treat families as a whole system, rather than focusing separately on the needs of individual members. Communication among services was seen as critical.

The **domestic violence** advocate talked about how staff are always listening for specific indicators of lethality (including presence of weapons in the home, threats to kill, criminal behavior, and presence of a nonbiological parent). Lethality assessment tools can help police and other providers quickly evaluate the level of danger and decrease fatalities. **Substance abuse** clinicians are trained to assess the impact

of a family member's addiction on the entire family, including children's safety. System coordination is important to facilitate the signing of releases necessary to obtain treatment. The **mental health** representative argued that the well-being of the entire family determines child safety. He believes that in order to protect children effectively, mental health services need to be applied in ways that are more family-based, rather than in silos of adult and children's services. Funding systems would need to support this approach.

NEAR FATALITIES

Joanne Wood, M.D., M.S.H.P., assistant professor of pediatrics at the Perelman School of Medicine, University of Pennsylvania, made the case that the study of near fatalities can aid in understanding and preventing of CAN fatalities. According to CAPTA, a near fatality is "an act that, as certified by a physician, places the child in serious or critical condition." Dr. Wood expressed several concerns with this definition: (1) *near fatality* is not a medical term, (2) definitions of *serious* and *critical condition* are not standardized, and (3) physicians are rarely asked to certify that an act of abuse caused a condition, and many are uncomfortable doing so. Because of the lack of consistent definitions across states, there are currently no reliable national data on the number of near fatalities.

However, Dr. Wood argued that near fatalities are important to study because they are similar in many ways (including child characteristics, perpetrator characteristics, and risk factors) to fatalities but occur in larger numbers, offering the potential to increase the accuracy of estimates and risk factor analyses. Two possible sources of data on near fatalities include state near-fatality data and medical data on serious injuries.

Dr. Wood offered several recommendations:

- Clarify the definition of near fatality at the federal level.
- Require near-fatality data to be collected and reported by all states, with core common data elements.
- Support states in conducting near-fatality reviews.
- Develop and validate standardized definitions of CAN near fatalities for use by the medical community.
- Standardize the utilization of child maltreatment diagnosis and cause of injury codes.
- Collect and report core data elements for cases of serious injury from abuse, either by adding core elements to hospital databases or by creating a separate child maltreatment database.

A PUBLIC HEALTH APPROACH: VERMONT'S PERSPECTIVE

The final panel of Day 1 examined the role of public health services and surveillance systems in the prevention of child fatalities due to maltreatment. Panelists included representatives from the Vermont Department of Health, Blueprint for Health, and the HRSA-funded Children's Safety Network. Some of the promising strategies they presented included Bright Futures (American Academy of Pediatrics), home visiting services, Help Me Grow, Strengthening Families framework, patient-centered medical homes, community health teams, CHARM (a multidisciplinary team to coordinate care for pregnant and postpartum mothers with a history of opiate dependence, including child welfare/safety planning), and Essentials for Childhood (CDC).

Panel members suggested that the following would support an effective public health approach:

- A commitment to primary prevention
- Build on health reform efforts, including family services within the child’s medical home
- Sustainable funding for effective strategies such as home visiting and Strengthening Families
- Federal policies that support timely exchange of information among providers
- Universal access to health care services (including parity for mental health and substance abuse services)
- Use of “big data” and predictive analytics to identify children most at-risk for fatalities
- Alignment, collaboration, and MOUs among related initiatives
- Flexible funding and the ability to “braid” funding streams to break out of programmatic silos

COMMISSIONER DELIBERATIONS

Counting

On Day 2, the Commission’s subcommittee on counting presented a summary of recommendations that have been provided to the Commission in testimony or identified in the literature up to this point. (This document will be available on the Commission’s website.) During the discussion that followed, Commissioners agreed that next steps for the subcommittee include addressing the following:

- Inventory the recommendations made in the 2011 GAO report on the subject of counting. What progress (if any) has been made toward implementing these recommendations?
- Analyze the recommendations that have been proposed to the Commission so far, to establish who would be responsible for each one (federal legislators, state policymakers, etc.).
- Revisit the purpose of counting, especially with relation to oversight and accountability.
- Revisit the definition of “children known to the child welfare system.”
- Consider system neglect—how might this be reflected in the count?
- Look at the issues around counting CAN deaths of AI/AN children.
- Consider the issues around counting near fatalities.

Confidentiality

Commission staff then presented a document summarizing testimony about confidentiality. (This document also will be available on the Commission’s website.) Proposed next steps included:

- Make confidentiality a focus of an upcoming meeting.
- Talk to other experts about the complexity and state of information sharing in child welfare, particularly around disclosure of information about child fatalities.
- Invite speakers who have conducted detailed, cross-state analyses on this issue to address Commissioners at an upcoming meeting.

Commissioners acknowledged that different issues are involved when agencies are sharing information externally (i.e., with the media) and when they are sharing information between agencies for the purpose of helping families. This issue will be moved to the subcommittee focusing on children known to the child welfare system, for further consideration.

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