



**COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES  
NEW YORK CITY PUBLIC MEETING TRANSCRIPT  
AUGUST 6-7, 2015**

**DAY ONE—AUGUST 6, 2015**

**Presenters:**

- Laura Velez, Deputy Commissioner, Division of Child Welfare Services, New York State Office of Children and Family Services
- Gladys Carrión, Commissioner, New York City Administration for Children's Services
- Dr. Rahl Briggs, Albert Einstein College of Medicine and Healthy Steps at Montefiore
- Dr. Angela Diaz, Icahn School of Medicine at Mount Sinai
- Richard Buery, New York City Deputy Mayor for Strategic Policy Initiatives
- Senator Daniel Squadron, New York State Senate, 26th District
- Dr. Jacqueline Mcknight, Executive Deputy Commissioner, Child Welfare Programs, New York City Administration for Children's Services
- Dr. Orixis Barbot, First Deputy Commissioner, New York City Department of Health and Mental Hygiene
- Lorraine Stephens, First Deputy Commissioner, New York City Department of Homeless Services
- Susan Morley, Senior Advisor for Investigations, New York City Administration for Children's Services
- Deputy Chief Michael Osgood, Commander of the New York City Police Department, Special Victims Division
- Andrea Goetz, Assistant Commissioner, Clinical Practice and Support, New York City Administration for Children's Services
- Dr. John Mattingly, Retired Child Welfare Commissioner, New York City Administration for Children's Services
- Dr. Rita Cameron Wedding, Chair, Department of Women's Studies and Professor of Women's Studies and Ethnic Studies, California State University, California
- Dr. Paul Elam, President, Public Policy Associates
- Chet Hewitt, President and CEO, Sierra Health Foundation
- Dr. Renee Canady, CEO, Michigan Public Health Institute

Efforts have been made to accurately capture the proceeding of this meeting.  
However, some slight discrepancies may still exist in this transcript.

**CHAIRMAN SANDERS:** Okay. So welcome to the Commission to Eliminate Child Abuse Fatalities hearing in New York. We have a full agenda, much of it focused on New York City and the work done here in the city, which we're excited to hear about, as well as some of the work done statewide. This commission was created through the Protect Our Kids Act in 2012 and the goal is to produce a report by March of next year that will provide recommendations to the Congress and the President to reduce and/or eliminate childhood neglect fatalities.

The 12-person commission was appointed by members of Congress and by the President and we've been meeting around the country for the last year and a half hearing about best practices, hearing about research, and hearing about policy. And so today, we have our final public hearing here in New York City. Before getting started, I want to make sure the commissioners have a chance to introduce themselves. And why don't we start at the other end with Dr. Bevan. Introduce yourself.

**COMMISSIONER BEVAN:** Hi, I'm Cassie Statuto Beven. I spent 20 years on Capitol Hill in child welfare, and like many of you, this is my life and we're going to do something.

**COMMISSIONER ZIMMERMAN:** Good morning, my name is Marilyn Bruguier Zimmerman. I'm an enrolled member of the Assiniboine-Sioux tribe in the State of Montana. I currently serve as the director of the National Native Children's Trauma Center at the University of Montana and I'm very humbled and honored to be in your presence today and I look forward to your testimony.

**COMMISSIONER RUBIN:** Good morning. My name is David Rubin. I'm a general pediatrician from the Children's Hospital of Philadelphia where I co-director the PolicyLab there.

**COMMISSIONER COVINGTON:** Good morning. My name is Teri Covington. I'm the director of the National Fetal Infant and Child Death Review Center which supports safety child review team efforts.

**COMMISSIONER DREYFUS:** Good morning. My name is Susan Dreyfus. I'm the president and CEO of the national Alliance for Strong Families and Communities, formerly administrator for Children and Families for the State of Wisconsin and secretary for Social Health Services in Washington State. There is no worse day of my life than when a single child dies while in our care and in our system. So I'm honored to be with you all today and look forward to your testimony.

**CHAIRMAN SANDERS:** And I'm David Sanders. I'm the Chair of the Commission and the executive vice president of the Casey Family Programs and also formerly the child welfare director in Los Angeles County, as well as Hennepin County in Minneapolis.

So today we'll have a chance to hear from a number of speakers and it will be an opportunity for the Commission to be better informed. We will not have an opportunity for audience questions, but we do invite written testimony from anybody who's here today. Let me get started right with the agenda. Our first presenter is Laura Velez, who's the Deputy Commissioner of the Division of Child Welfare Services for New York State. Deputy Laura Velez. And as you're coming up, I'll just to remind all the speakers it's a tight time line and so we adhere closely to the time now with these.

**LAURA VELEZ:** Good morning. Welcome to New York State and to New York City. It is truly an honor to have all of you here. You know, child welfare work is not for the faint of heart and it is always comforting to be in an environment surrounding when you're having discussions like this with people who understand that and who know that feeling that comes over you when you are the director of a system and there has been a child fatality. So there's an emotional component to that work and then there is the work that goes with that work, and we have to be able to hold both of those things, and it's not an easy thing to do, so I appreciate the experience that all of you bring to this.

I wanted to just frame for you very quickly New York State and New York State Child Welfare System just to provide you with some context in terms of what you might hear today. So as you might know, New York State is a state supervised locally administered system. We're one of 13 states that are arranged that way. So the local social service districts employ the workers who do the child welfare work. The state provides oversight, monitoring, and technical assistance. We operate a Statewide Central Register that receives roughly 350 to 60,000 calls per year. And where we register the reports that rise to the level of a reasonable cause to suspect, and I mean child abuse, and we move them on to the counties for investigation.

We accept roughly 60 percent of the calls that come to us. And this is where the reports of child deaths come to be investigated by child protective services. In the last five years, we have reviewed over 1600 child fatalities that came into the State Central Register. This represents about fourteen percent of the total number of the child deaths in the state that are tracked by the Department of Health. So again, just trying to give you some context here in terms of scope. The number of fatalities that we investigate or that the local districts investigate annually has stayed approximately the same over the last five years.

We average about 270 fatalities through the child welfare system on an annual basis. And again, that number has not really fluctuated. New York City accounts for roughly 40 percent of those. So the remaining six percent are from, those of you who are familiar with New York State, New York City is not the epicenter of New York State. My apologies to everyone in back of us, but New York City comprises a very small geographic part of the state. The other 60 percent of those fatalities come from everything north of New York City from Westchester to Buffalo to the Canadian border.

Unsafe sleep, when we start looking at our patterns in fatality, unsafe sleep continues to be the leading cause of child fatalities for infants. Fifty-six percent of the child fatalities reviewed by OCFS over a three-year period were under the age of one, and about half of those had at least one sleeping risk factor associated with that death. The number one cause of those child fatalities in the unsafe sleep environment is related to the infant sleeping in an adult bed. And co-sleeping was noted in the majority of those cases. Usually there are other risk factors, the parents were under the influence of some other kind of substance. Other types that we've noted, suicides are occurring and predominantly occurring in the 12 and older age group and they are on the rise. Children under the age of one continue to represent the largest group of fatalities each year. And fatalities among boys is greater and increasing over the number of fatalities in girls.

Just a few things related to our preventive activities. We have child family or child fatality review teams across the state, not one in every county, but many of our counties have them that we fund. We use those as a way to look at patterns and trends and counties work with their multidisciplinary stakeholders to determine what they might do to try to prevent some of these deaths. We fund and support home visiting programs as a method of preventing child abuse and maltreatment. We have a program in New York State that is evidence-based and has quite a bit of research behind it called Healthy Families New York. And we have 36 of those programs in the state, including 12 in the boroughs of New York City.

Regarding safe sleep, because this is the number one cause of death among our infants, this past March we convened a group of representatives from the social services and medical field and we are working with our partners at the Department of Health to develop a statewide response to the stats and to try to create a higher level of awareness in the hospitals with newborn's parents. We've been asked to co-lead the safe sleep workgroup under the Department of Health and National COIN Initiative and we are one of 37 states that is focusing on reducing infant mortalities under the federally reported program.

So I know that I'm probably about out of time, but again, I'm very glad that you're here. I'm glad that if you had to have a last stop that it's in New York State. We're very interested in hearing from you and from the people who are going to be presenting today. Clearly, this is an important issue. It is what tortures us. And I don't think that that is an overstatement or too melodramatic. These events are what tortures our workers, our administrators, our communities, our politicians, everyone that rallies around and who wants to do something that is better. So thank you for your efforts and we look forward to hearing from you today.

**CHAIRMAN SANDERS:** Thank you very much. And you'll be here to ask questions afterwards?

**LAURA VELEZ:** Yes. I will.

**CHAIRMAN SANDERS:** Thanks. Our next presenter is Commissioner Gladys Carrión who is the Commissioner for the New York City Administration for Children's Services. Thank you for taking the time, Commissioner.

**GLADYS CARRIÓN:** Absolutely. It's my pleasure and an honor to be able to be here. We welcome you to our city. Unlike Commissioner Velez, I do think this is the epicenter of the world. So it's an honor to be able to present at this stage and kind of thank you for the work that you're doing highlighting this very, very serious, important, and vexing issue that all of us in the child welfare field face day-to-day. I hope the presentations and discussions in New York City will play a part in the better understanding of the issues that lead to child fatalities and help shape the solutions that promote safety and well-being for the entire family. This morning I will provide a brief overview of child welfare work in New York City with particular focus on the process of reviewing cases involving fatalities of children who are already known to our system, what we've learned from our review of these fatalities, what we're doing to prevent child abuse neglect fatalities, as well as the challenges and opportunities that we face.

As you've heard, we have a state supervised and locally administered system and the Administration for Children's Service, ACS, the agency that I lead, is the designated child welfare agency for New York City's Social Service District and is required by law to investigate

all reports of possible child maltreatment that we receive from the State Central Register. A quick snapshot of our child welfare system. Each year,

ACS receives approximately 55,000 reports of child abuse or neglect. Child protective specialists are the front-line staff that investigate maltreatment allegations. In New York State, CPS investigations can lead to one of two results: Indicated means that one or more of the allegations were substantiated; and unfounded means that all the allegations were unsubstantiated. The standard for substantiating an investigation is that CPS or child protective workers must find some credible evidence of maltreatment, a different standard than many other states. If we do not find some credible evidence, the case is procured unfounded.

In about 40 percent of cases in New York City, CPS finds some credible evidence of maltreatment, a rate that's pretty high in comparison to many of the other counties in New York State, which I think the average is about 30 percent if I remember. The number of investigation as well as the number of fatalities that involve allegations of maltreatment have remained relatively constant in New York City over the past several years. Over the past five years, we've investigated an average of 56,800 cases each year and I have seen an average of eighty-eight fatalities a year. Similarly, the number of fatalities of children of families that are known to the child welfare system also remains relatively constant, averaging around 48 a year during the past five years. These fatalities include unsafe sleep death, accidental injuries, as well as death from natural causes, including children with severe medical challenges and a small number of homicides, which number about 10 a year.

Since 1988, New York City has convened an Accountability Review Panel to examine fatalities of children whose families are known to

ACS. A family is considered "known" if it meets any of the following criteria: An adult in the family has been the subject of an allegation of child maltreatment reported within 10 years before the fatality. When the fatality occurred, ACS was investigating an allegation involving an adult in the family, or when the fatality occurred a family member was receiving ACS services, such as foster care or preventive services. The panel consists of a multidisciplinary group of child welfare experts, including Family Court representatives, social work practitioners, pediatricians, OCFS, as well as representatives from the police department, the schools, the public hospital system, the Department of Homeless Services, the fire department, medical examiner, and the Department of Health and Mental Hygiene from whom you will hear later today. So it's a very robust panel.

The Accountability Review Panel only reviews cases that were reported to the State Central Register. Fatalities that are reported to the SCR in families previously unknown to ACS are investigated, but not reviewed by the panel. Fatalities may also be investigated by the police and the district attorney's office. ACS's staff compiles and then takes summaries of each fatality that meets the criteria of a family that is known to ACS. The panel, joined by representatives of ACS, reviews each case individually in order to ascertain certain characteristics and compile common trends and themes. From their analysis of each case, the panel makes recommendations focusing on strengthening case practice, safety assessments, and supportive services. It also makes case-specific recommendations whenever appropriate. The panel's findings and recommendations are disseminated in a report.

Some specific recommendations of the panel have included raising awareness about unsafe sleep conditions, strengthening investigation of all people involved in the household, including cohabitants and romantic partners of a custodial parent, better identifying children of special medical needs, and stressing the importance of healthcare, and bolstering home visiting programs for families with young children. The Accountability Review Panel has found some common characteristics among the cases they have reviewed. A significant -- and I would stress significant -- number of families experience domestic violence, substance abuse, homelessness, housing instability, and mental health issues. Families on average have three children. They have a wide range of contact with ACS with an average of 3.5 prior reports per family to the state registry. About half of mothers were also subjects of reported abuse and neglect when they were children. Fatalities most often occur when the child is an infant, most of whom are under three months old. A significant number of fatalities are attributed to unsafe sleeping conditions, as we've heard; in fact, you will hear more detail shortly.

In recent years, among half of the fatalities of families known to ACS have been attributed to unsafe sleeping conditions, and you will hear more about the work and our partnership with the Department of Health, Department of Homelessness, and our hospital cooperation. About 30 percent of cases reviewed by the panel are deemed homicide by the medical examiners' office.

So what are we doing to prevent child fatalities and promote safety and well-being? Coordination, coordination, and collaboration is critical. We have over 6,000 staff and over 80 contracted child welfare service providers. Let me share with you that I feel strongly that it's not just the responsibility of the child welfare system in the City of New York, but it's a shared responsibility among many, many other systems that touch the lives of these families and children and we have to do better in coordinating those services and sharing that responsibility.

I often say to my colleagues, these are our children, not just my children. So when I arrived at ACS, child welfare work was divided into separate units according to each phase in the process. An investigative worker passes along the case to the preventative services caseworker who passes the case to the foster care or the adoptive worker. And one of the first things I did at ACS was to unify our three child welfare units under one single umbrella of child welfare programs to build greater collaboration. I have been a city commissioner now for about 18 months, not that I'm counting the number of hours and days, and prior to that I had the privilege to be a state commissioner for seven years. And Commissioner Laura Velez was my deputy then and now she's my boss.

Safety and risk need to be part of our work when we engage families in preventive services, and permanency planning begins as soon as the CPS receives the case, and we need to organize that work accordingly. One of the ways we are working together is through a workgroup and frequently encountered families, as I mentioned earlier, the average fatality known to our system at 3.5 maltreatment reports. We're looking at all the points we engage with our families to find ways to collaborate. We are working to strengthen our case planning and ensure that each handoff is as smooth and as much information as possible is shared. Assessing safety and risk is the most important part and challenging part of our work. We depend on the dedication and judgement and commitment of over 2,000 bottom line staff.

Making these assessments is critical. When we can make better assessments, we can better meet the needs of our families.

In 2014, New York City experienced several high-profile child fatalities just as I was walking in the door. We were saddened by these deaths. We also were relieved to have a mayor who has a commitment to and an understanding of our complex work. With his support, ACS embarked on a series of reforms to bolster our practice throughout our continued work in child welfare services. We have assumed caseloads and supervision ratios in child protective services by hiring 362 new positions and creating additional units that oversee our highest risk cases.

In foster care, thanks to the flexibility provided by our title IV-E waiver, we've been able to reduce caseloads or share caseloads as well, which is now down to 10 active and two inactive cases per caseworker. And what we decide are inactive cases are those that are child discharge. Reducing caseloads allows our staff and our provided staff to focus more time on cases and drill down deeper.

We know that time, in and out of itself does not promote better case practice, so we are also giving staff access to tools to help them better understand the needs of families and new approaches that engage rather than punish families. Unfortunately, too many families do hear that they're bad parents instead of, how can we help you to do better. One of the ways that we've increased family engagement is to integrate parent advocates, many of whom have had prior child welfare experience, at child safety conferences to serve as mentors and consultants to families newly involved with child protective services, including parent advocates, has helped to empower parents in a safety and planning process.

With more support and guidance, we have found that parents feel more comfortable speaking more openly about their strengths and their needs which result in better matching of services. In 2014, parent advocates attended over 3,700 child safety conferences. To better identify safety concerns, we have emphasized greater integration of assessment in our investigation, like the state's risk assessment profile which assesses the likelihood of repeat maltreatment and case planning that can better serve our families. We are also joining other jurisdictions in developing a predictive analytics tool that will harness data from thousands of cases to better identify risk.

Within foster care, we've rolled out Child Assessment of Needs and Strength Care, a tool which walks through 101 measures of children and their caregivers' strengths and needs. Since 2014, our foster care agencies have completed more than 14,000 of these screenings. Training and supporting our workforce continues to be a major priority for us. We have invested \$10 million to launch a workforce development institute in partnership with our City University of New York that will provide continuing education and offer the latest in investigative techniques, family engagement, strategy, and brain science. Collaboration both inside and outside the agency is critical to our agency.

ACS employs over 100 investigative consultants that are retired law enforcement for assistance in screening, investigations, and law enforcement contact. With assistance from the investigative consultants, ACS screens for domestic violence in every single case we investigate. We will soon hear from Susan Morley, a former New York City Commander of Special Victims Division who serves as our senior advisor for investigations. We'll hear from

Andrea Goetz, who leads our clinical consultation unit that has teams of mental health coalitions, domestic violence specialists, and others who support our front-line staff in their work. To add to the multidisciplinary approach, we collaborate with medical consultants who also help to assess risk and safety. We must acknowledge that our children of color are disproportionately represented across this system. I'm pleased to note that the Commission will address this issue in today's session.

At ACS, we are actively working to find solutions that will change and clarify and build awareness of the systemic issue along the entire continuance. On the front-line, we are expanding mandatory training for child protective staff and caseworkers to increase the cultural competence and meet the challenges of working in our incredibly diverse neighborhoods, understand bias, and undergo anti-racism training. Some of the disproportionality begins at the front door with those who work for the State Central Registry. We're looking at working with mandated reporters, such as education and public hospital systems, which comprise our largest referral source. To make sure that they're making the appropriate calls. We're also looking at programs initiated by Nassau and Monroe Counties in New York who use the practice of blind removals, where decision-making participants in a potential removal attend meetings and they're not provided with any demographic information that reveals the ethnicity or race of a family or children.

Prevention is always the best intervention. ACS oversees 59 community-based organizations that offer nearly 12,000 preventive service slots serving 25,000 families a year. Our providers are located throughout the City of New York and many are fixtures in their communities. For the past year, our preventive programs have been operating at or above 90 percent utilization rate. We have services ranging from individual and family counseling, support groups, and domestic violence counseling to help families access benefits and the supports they need. We also collaborate with the city's Youth Development Agency to provide school-based community programs.

Within the last few years, ACS has expanded our continuum of preventive services to include 11 evidence-based models, which require staff to participate in intensive training and contain a quality assurance system. One evidence-based model, for example, child-parent psychotherapy focuses on the impact of trauma, of parent-child relationship, and seeks to support and strengthen the relationship by helping parents interact with their children in developmentally appropriate ways. Child welfare agents need more of these interventions that give parents and children insights into themselves so they can understand what their triggers are, what they need, and how to cope. We've learned from our child fatalities that infants are at the greatest risk for serious injury.

We've invested tremendously in targeting services for families with children under the age of five. We know from research that developing healthy bonds between parents and their young children is a significant protective factor. This year, we're adding 240 new slots focused on this population for programs like SafeCare, which visits families in their homes every week and trains parents by explaining and modeling skills and providing feedback. As part our title IV-E foster care program waiver, we're launching an Attachment Bio behavioral Catch-up program in high- risk neighborhoods to provide 10 weeks of in-home coaching that both help the infant and parent. We're aiming to bring this program citywide. Many families involved in a child fatality have a mental health issue at the time of the child's death. Consistent with

the panel's recommendation, I issued guidelines for staff on assessing parent's mental health. In addition to our existing evidence-based models, we are just launching the Partnership for Success program, which shows about stronger relationships with caseworkers and mental health clinicians. As a result, children and families access cognitive behavioral therapy plus, which has been proven effective in addressing trauma, depression, anxiety, and other mental issues.

**CHAIRMAN SANDERS:** Ms. Carrión, I'm going to have to ask you to wrap up in just a minute.

**GLADYS CARRIÓN:** Sure. So poverty, we have to recognize is an underlying condition for so many young families. Poverty does not cause child abuse and neglect, but it places extraordinary stress on families. Assessing the economic stability of families is critical to addressing their safety and well-being. This administration is committed to making a far more equitable place for all where we work to advance for a living wage, we make it easier to obtain benefits, increase affordable housing, informed sick leave, and expand early education, and we strengthen our children, our families, and our communities.

We've taken numerous actions. We've started a New York City Children's Cabinet. We have more than 23 different city agencies with a goal of promoting consistent and meaningful communication to ensure child safety and well-being. You're going to hear from our deputy mayor about the Children's Cabinet in a few minutes. It is where the mayor has challenged each and every city agency to be part of the work of the Administration for Children's Services to keep all children safe, to support families, and to promote the well-being of children.

I will end with saying that it is really important, not only to maintain our children's safety but to promote their safety, to promote their permanency, but also to make sure we're focused on their well-being and we're focused on their outcomes, that children don't suffer because they come into care and that our system is deficit based. That is the work that we are undertaking in New York and we're more than happy to share that work with you. Thank you so much for giving me the opportunity to share the work of New York City and I look forward to any questions you may have. And welcome to New York City.

**CHAIRMAN SANDERS:** Thank you very much. That was very informative. Commissioner Rubin

**COMMISSIONER RUBIN:** It's great being in New York City. I'm really excited that we're finishing our commission hearings in New York. My mom is a 35-year lifer in the public school system in Hell's Kitchen, so I grew up around this area. I've long admired both the Administration of Children Services here in New York just for their commitment, as well as the Public Health Department.

There's a rich tradition in New York City in terms of some of the public health approaches to helping families and just folks in general, and so I'm hoping we can learn over these next couple days a lot of what it took to kind of get folks to work together. And so this question I ask to you I'm also asking to all the presenters today, one of the things we've learned throughout the country was that -- and I think this is a value we hold -- is that the child welfare system for children is not just child protective services. It's not just ACS. It's a collective of a lot of different programs, public health, Medicaid, WIC, childcare that come together to support families with a more upstream approach thinking about how to reduce the risk of serious harm to children.

The challenge in a lot of communities that we've sensed is that when ACS is given the responsibility to kind of coordinate the upstream efforts to try to reduce risks to families, they often have a hard time bringing Medicaid to the table. They often have a hard time really positioning so that it's very easy to access, that it's really difficult to access home visiting so that the moment that a family risk is identified, we can get a young mother, particularly a mom that may have been raised in the child welfare system, in child protective services.

I'd like the folks here today to talk a little bit about to the degree that it has been successful and I'm looking forward to the Deputy Mayor's comments as well, too. What did it take to get some of the public health partners around a table in a meaningful way to create accountability? And to the degree that it hasn't been successful, I would like you to be very candid with us about what we could do to achieve a higher level of accountability from the partners of ACS around a collective strategy to reduce the risk in homes.

**GLADYS CARRIÓN:** Let me share the fact that I do think that with this new administration, it's been a very collaborative effort on the part of many city agencies and the Children's Cabinet has helped to develop those relationships. It's helped to identify the inefficiencies, the unintended consequences of policies of different agencies, and really create those bridges to each other's services.

I would suggest that one of the things that we have to do to be able to incentivize that behavior is to model it on the federal level. And to have more collaboration and working together among federal agencies and collaboration with the Department of Health, with the Department of Justice, and to really show us that that's the way we need to do our work and that there is a shared responsibility.

I will share with you that we have a wonderful working relationship with our Department of Health and Mental Hygiene, a deep collaboration where our staffs are meeting all of the time working together to find solutions. We have that with our Department of Homelessness. Twenty-five percent of the families in our Department of Homelessness and our shelter system are child welfare involved. So we understand there's a shared responsibility. Our staff is collocated there. We do joint training. We're working together on our safe sleep initiative. So there's a lot of work with our departments.

Much credit goes to that commissioner who reached out to me and said, you know, Gladys, whenever we terminate or impact on someone's benefits and they're involved in your system, that has real impact and really can destabilize a very vulnerable family. Let's think about how our systems can talk so that I can give you an alert whenever we're going to take an adverse action to one of your families. We're actually working that out right now. So there is an understanding and appreciation that we have a shared responsibility to keep families and children safe and to support their access to benefits and the support they need.

I'm very proud to be able to say that I'm part of an administration that owns that, understands that and is working actively together to really find solutions that work to keep and support our families.

**CHAIRMAN SANDERS:** Commissioner Dreyfus.

**COMMISSIONER DREYFUS:** I want to ask a more technical question. One of the things we're finding as we go around the country is very different definitions of "known to the system." And you have a very specific definition of known to the system that I was intrigued with, especially about when there has been an adult involved in your system within 10 years. That is, like, way outlier of anything we've heard around the country. Would you be supportive of there being a common federal definition of the definition of a child fatality by abuse and neglect that would bring us to a greater consistency of definition of what is a fatality by abuse and neglect that would include this definition of known to the system? We're finding that we just don't have a good count, and until we get a good count, it's really hard to know if we're making any difference. So I just wanted to hear a little more about that because I was really intrigued with that 10-year mark.

**GLADYS CARRIÓN:** I can't agree more. I really do, I think that it's important to be able to set expectations, to be able to have common definitions and also to be able to do comparisons across the system. Unfortunately, they are constantly compared and it's apples to oranges. And that becomes a real problem. It also helps us to better identify what the challenges are and where investments need to be made.

**COMMISSIONER DREYFUS:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Bevan.

**COMMISSIONER BEVAN:** I am really struck by the average of 3.5 prior reports with fatalities. This is something we have found across the country. And certainly prior reports are risk factors for fatality. What do we do here? What's happening here? I mean, there's prior reports. What's happening and why aren't we catching something? What are we missing? Is it prevention programs, family support programs, family preservation programs, what is it? Because child safety has to be paramount, and yet, there's 3.5 prior reports before the child is killed.

**GLADYS CARRIÓN:** So I have given that a lot of thought and continue to give that a lot of thought. I think that one of the challenges that we have, at least in New York, and I'm sure across the country, is the stigma attached to being involved with the child welfare system and really then coming to get help and the reluctance to do that. We run really robust preventive services.

In the City of New York, we spent close to \$200 million in providing preventive services and an array of evidence-based interventions, an array of community support, but it's hard to get families to engage. So we have to do a better job of learning how to engage effectively with families and working with families, but we also need to destigmatize it and really ground them in community and look at a different model. You know, this reputation that if a family seeks services that we're going to grab and snatch their child is a reality, and that really is a barrier I think to accessing services early on and to engaging. And it's something I struggle in and we're actually looking at, is there a way to redesign our preventative services.

I remember many, many years ago when I started doing this work -- and I actually ran at one point a preventive service agency -- and I remember that we were grounded in a community. People walked in voluntarily. It wasn't as bureaucratic. People weren't reported to the system

the way they are now. And we've created a very bureaucratic, a very legalistic, law enforcement driven system and we need to find ways to change.

**COMMISSIONER BEVAN:** But these mandatory repeated reports. These are reports of suspected - - these are not voluntary walk-ins that say, I know I kind of need help. What happens when you have three prior reports? Assuming they are substantiated.

**GLADYS CARRIÓN:** Well, assuming they're substantiated, well, even when they're substantiated, we need to be able to engage families to receive services. So it's one of the things that we're doing, you know, so many of our cases are safe sleep cases. They're very hard to predict. We're also creating a predictive analytical tool to be able to mine the data, to be able to look at those risk factors and engage earlier with families. And I think that's going to be an important tool for us to use. We don't really use technology, so we lack the systems that we need in order to be able to do a better job.

**CHAIRMAN SANDERS:** Commissioner Martin.

**COMMISSIONER MARTIN:** Thank you. Good morning. Thank you so very much for your remarks. I would like to follow up on a question that my fellow Commissioner Rubin asked. I think it's wonderful that New York is recognizing the need to share the responsibility amongst the shareholders. It appears that a lot of that is done based on personality and then the recognition of needs to communicate with your agency, housing, and other agencies. Is there any attempt at this point in New York since you have developed this relationship to kind of institutionalize those responsibilities? So is there any attempt rather than this MOUs to start making certain that there is a design within the Children's Cabinet to institutionalize that shared responsibility?

**GLADYS CARRIÓN:** There is. I think it's looking at how we change systems, which is really very hard, in addition to culture, right. So that's evolving. The Children's Cabinet has been about a year in operation, and that is part of the learning, but for instance, one of the things that we're doing to work together with the Department of Homelessness for instance is, how do we create the pathway and the protocols to ensure that every child -- that it's automatic that every child that's born on the earth is in one of my early learning programs, my early care and learning system, how do we identify those children, our systems identify those children, how does that automatically happen from their system to my system? And it's working to how do we make that happen?

The same thing -- it's very interesting - - and I've run the juvenile justice system. I've run the child welfare system and the early care and learning system. In my early care and learning system, any one day, I had 110,000 children in a daycare setting. So how many -- are all my children in child welfare in a quality early learning program? How do we ensure that? So even within my system of creating those bridges and understanding that within these divisions, and breaking the silence is always a challenge, and that, across agencies continues to be a challenge and we are committed to working through those challenges.

**COMMISSIONER MARTIN:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Covington.

**COMMISSIONER COVINGTON:** Thank you. I wish we had a lot more time to hear more in New York City. It seems to be a kind of pretty neat microcosm of what the Commission has been talking about for the last year. Commissioner Dreyfus just whispered in my ear, this is our 21st century model of child welfare, which is that it's not about just CPS. It's about figuring out our link in support services. And I think we've really struggled to think about how you do try to institutionalize or how you change federal policy to sort of force that sort of shared responsibility across systems. I had two specific questions. Are you doing anything specifically with Medicaid or with your -- with public financing of healthcare services in terms of providing some sort of level of care for families beyond just paying? Are you doing anything innovative in that area?

**GLADYS CARRIÓN:** We are working and redesigning the entire state system around Medicaid. And I think in fact, fortunately Laura was here and Laura has been, Commissioner Velez, has been the lead in the state in working on how we design that system for children and making sure that for children in foster care that we have a very robust system that provide for a very high level of care that they need. I think one of the challenges that we have is that we don't know each other's systems, right, and being able to learn. And so there has been a big learning curve, both on the part of the state and the city, and we actually are bringing -- we just hired an expert at ACS that will help us navigate the Medicaid system and how it's redesigned, how we hope to redesign it in a way that better meets the needs of all the children across the age continuum, because there are different challenges at each point for the children in care.

**COMMISSIONER COVINGTON:** This question might be a little too specific to get an answer right away, but you talked about the blind reviews and we are doing quite a bit of our focus this afternoon on blind reviewing, the disproportionality of children in child welfare, but are there any outcomes that we can talk about?

**GLADYS CARRIÓN:** No, there isn't.

**LAURA VELEZ:** There is in other counties.

**GLADYS CARRIÓN:** In Monroe and Nassau. We actually -- Monroe and Nassau are the two counties that we are familiar with, and we actually recently had a conference call with Nassau County to learn how they did it. It's a small county so their ability to do it is greater than ours. They're not as highly segregated a city in the way we're organized by neighborhoods.

We know who lives in those neighborhoods, so it's hard to think about how we're doing it in New York City, but we are thinking about it, but it's very anecdotal. They, at this point, they have not been collecting data in a systemic way for us to be able to measure. They do feel that it's making a difference in the removals. They're seeing that they're removing less children, African American children, but the evidence, they have not had a rigorous data collection or evaluation yet.

**COMMISSIONER COVINGTON:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Rodriguez.

**COMMISSIONER RODRIGUEZ:** I really appreciated your summary and thank you for hosting us here in New York City. You know, one of the things that we've learned as we've gone across the country is that there is not a very good feedback loop coming back to through the system about what type of services are actually effective for families and sort of helpful in addressing the conditions. And I know you're doing sort of all of the best practice, evidence-based programs that are out there, including the Attachment and Biobehavioral Catch-up, that makes me very happy.

I also think you have here in New York City probably the most robust parent advocacy program in the country. So you have more opportunities for parents who have actually experienced the conditions that would lead to removal and who are really struggling and who have been successful in stabilizing and getting their children safe and healthy and happy. And so I'm wondering, you spoke to sort of what they can offer to other parents in engaging them and reducing the isolation and helping with safety plans, but I'm wondering if you could speak to at all what your system is learning from having parents in that role about how to self-improve to be more effective in serving parents.

**GLADYS CARRIÓN:** So one of the things that I recently did was actually create the first office in OCFS for parent's engagement in youth advocacy. So we have a dedicated office now with a director who really is helping us to better engage the parents and find ways to include them in our work to be able to get that input. I recently had a focus group with a group of parents to really talk about their experiences and how as a system we can better include those experiences in our work and how does that inform our work and how do we need to do our work differently.

And so I, both not only with parents, but also with young people, one of the things I found striking was that we didn't have a formalized mechanism to really get parent input and youth input and a youth voice in our work. And so we're really in the very beginning stages. We do it in our practice through our parent advocates in our conferencing approach, but really looking at how do we integrate the parent voice into our work is still something that we are developing and working at.

**COMMISSIONER RODRIGUEZ:** I just wanted to say that at our last commission meeting, we heard a lot about sort of as a safety improvement culture looking at cases where situations worked and trying to extrapolate from that what can we learn to apply to the other systems. So anything that I think you all can share with us, because we have not heard strongly from the voice of families who are actually directly impacted throughout this process about what you're hearing from parents about what works. I think that would be really valuable to our commission as follow-up information.

**GLADYS CARRIÓN:** We actually can provide that and the results of our focus groups. We have had a number of focus groups with parents and young people. And part of also, we do, as you know and you'll hear from Commissioner Mattingly, who is the prior New York City Commissioner who started ChildStat, we have developed a ChildStat in New York City where we do those case reviews and we learn from what works and what doesn't work and how does that inform our practice and our learning. We now are -- one of the changes that we've implemented, we really look at particular themes and issues. We've looked at a series of domestic violence issues. We looked at substance abuse cases. We've looked at ASAC's process

in, how do we engage parents? How are we listening? Are we not listening? What has worked with the parents and what hasn't worked? I think I have other things that we need to do better and we continue to struggle with, how do we include that parent's voice. And that's the convenience that I'm doing to be able to help inform the work that we want to do at ACS.

**CHAIRMAN SANDERS:** Commissioner Petit has the last question here.

**COMMISSIONER PETIT:** Thank you very much for your presentation and all of the information. And I highly endorse all of the preventive interventions that we're hearing about and all the advocacy work you're doing on behalf of families engaging families. And you made reference to the fact that we have a system maybe too legalistic or too driven by law enforcement, which I agree that in many places that's true. In some other cases, it's not true enough.

So if we just take your situation -- and I didn't see what your fatalities for 2015 -- which we're six or seven months into it, I don't know if you've got the number you're working with, but the 2013 number was 107. And then looking at the cases, it looks like at least half of the kids that have been killed over the last few years were known to the department in one fashion or another. So it's safe to say that that's likely to continue and that in this year of the 100 or so children going to die, some 50 of them are already known to you.

So in those cases where they were killed, the system may not have been legalistic enough or might not have been law enforcement driven enough to getting orders to keep somebody out of the household who's threatening domestic violence or somebody who's gotten out of prison or somebody with severe active mental health problems or severe active substance abuse issues. So just confining ourselves for a moment to that population of 50 children, 100 altogether, but 50 that you already know about, and I know there's going to be discussion this afternoon about the instant response. But as the senior person in the operation, what do you see specifically you do in those cases?

There's an irreducible number of families, we can probably all agree that there's an irreducible number of families that no matter what we do, it's just not going to be enough. We just don't have enough knowledge about human behavior, et cetera. So what are you seeing, if anything, as the kind of interaction with the Courts, police, and the DAs in those small percentage of cases in which it's more than engaging parents, it's actually a public safety issue where the child is on the road to a fatality?

**GLADYS CARRIÓN:** That's a hard question I have to admit. Those cases are few that we -- actually very few cases. The major number of cases that we have are due to unsafe sleep conditions. You know, I struggle with that. I really do struggle with that. What is it that we can do better, what can we do different, and I think we need to be able to do better assessments of families, do better engagement, and we say engagement is not enough, but engagement, and to be able to understand -- which I think we still don't have -- the other systems' involvement.

Mental health is a real factor in many of these cases. Our inability to assess that appropriately, to be able to bring the services and have them available, and the consistency of those services continues to be very challenging. How we help individuals understand that they need these services to be able to participate in the delivery of these services continues to be a challenge. We don't have, as rich resources as New York City has, we don't have the

type and level and consistency of services in communities around mental health issues. We don't understand those issues well, and therefore, we don't know what the right intervention is. We don't have enough trained clinicians and psychiatrists. It has been one of the incredible things is really resourcing that and bringing those services and supports into our system. We lack adolescent psychiatrists in New York City and across the country. We don't really have a good understanding of what works for a given individual in terms of mental health interventions. And I'm pleased to say that the First Lady in New York City has taken that on in creating a road map of mental health supports. But I think that's a challenge.

**COMMISSIONER PETIT:** It is a challenge for everybody. It's a challenge for the country. We see per 100,000 children there are only two that are killed, and I say only, but it means 99,998 aren't killed, and how are you going to intervene in all of those in order to protect two, but when you have an active mental health situation, when you have an active criminal behavior situation, is there a default position that defers, that errors on the side of the child? What does it take to intervene in a manner that -- it's never nice to remove a child? We all understand how challenging that is to everybody, but the parent is essentially not going to be able to protect, the mother isn't going to be able to protect, she can't keep him out of the house or something, what vehicle do we use now in order to bring in people who have authority if you don't have it?

**GLADYS CARRIÓN:** We have a very close working relationship with our police department and our courts. We do not hesitate to remove a child when we assess that there's imminent risk to this child. I don't think that we, as much as we understand the trauma that is inflicted in a removal, we understand that removals keep children safe and that that's our primary responsibility is to keep children safe. So the police, our police department, is a partner with us.

We have the luxury in New York City to have investigative consultants that have long law enforcement experience that helps us to assess cases to be able to identify that risk and to look at in a very thorough and deliberate way a domestic violence history, a criminal history. We have access to those reports. I think one of the challenges in New York, we've submitted legislation, it has not been passed by the state legislature, is to give us access to arrest reports, which we don't have. We need to have better information about who is in that household who poses a risk. And so that's been a challenge for us. And we had a situation where we knew of the arrest -- the criminal conviction history, but we didn't know that he had been arrested, that he had a pending arrest.

**COMMISSIONER PETIT:** So the last point on that, just to close on this thing, was exactly the case you just described you didn't know, it wasn't forthcoming and so forth, what capability do you have now for a look back or a redundancy, if you will, that does a review of cases that are maybe open but you haven't looked at in a while or the only person looking at them is a CPS worker and supervisor, do you have the wherewithal to go back and randomly select 1,000 cases that are involved with -- where something has happened sadly that fell through?

**GLADYS CARRIÓN:** We absolutely do. And we have a continuous quality improvement on case review. I personally, when I came on board, I'd like to say I personally viewed 1600 cases but I didn't, but we actually did a case review of 1600 cases to look for those patterns and to look

at safety alerts right after a child fatality. We said, let's look, make sure every child is safe. We actually went out and touched every child in our caseload that was in care to assess.

**COMMISSIONER PETIT:** Did you bring some of them back into care?

**GLADYS CARRIÓN:** I'm not sure if we brought children back to care. We probably did, one or two. We actually did do assessments. We put services in there. We went back into court to mandate when we needed that support from the Court, and I'm sure we probably did have to do a removal or more, but we certainly do those look backs.

**CHAIRMAN SANDERS:** I promised that Commissioner Petit had the last question but I see Commissioner Zimmerman also has a question. Commissioner Zimmerman, you'll have the last question.

**COMMISSIONER ZIMMERMAN:** I'm sorry, and I hope it's not very involved and can be answered throughout the day. Going back to disproportionality, I'm intrigued by the fact that you said that when you do a removal, that the group that gathers together doesn't know the race or ethnicity of the child or family, so a lot of the -- can you sort of describe how you get to that place where you're having that discussion about removal, because so often when we're involved in child welfare cases, it's actually the culture that's a protective factor and can be integrated into some of the services that were provided to the family, so after you've done that, how do you get to the place where suddenly it's no longer -- race and ethnicity is no longer on the table?

**GLADYS CARRIÓN:** Commissioner, we don't do that in New York City. Those are two counties, Nassau and Monroe County, that have that practice, and it's an early practice that they're looking at and we're looking to see whether or not that affected and if that impacted at all disproportionality, but New York City does not do that yet.

**COMMISSIONER ZIMMERMAN:** So I'll talk to somebody from Monroe or Nassau. Okay.

**GLADYS CARRIÓN:** Yes. You can talk to Commissioner Velez.

**CHAIRMAN SANDERS:** Thank you, Commissioner Carrión, for being so generous with your time.

**GLADYS CARRIÓN:** Thank you.

**CHAIRMAN SANDERS:** And I also want to thank the next two presenters for being so patient. We will call up Dr. Briggs, Rahil Briggs, and Dr. Angela Diaz to talk about dual generation approach that prevent maltreatment fatalities.

**DR. BRIGGS:** Good morning. Thank you for having me. I'm Rahil Briggs. I'm from the Montefiore Medical Center in the Bronx, New York. For those of you who aren't as familiar with the Bronx, it's one of the boroughs of New York City and one of the counties, obviously, of New York State. We have 62 counties, and unfortunately, the Bronx usually ranks around 62nd in most outcomes for children and for families. As the largest healthcare system in the Bronx, that's on us, and we've been doing everything we can for the last 10 years to preventively make that change.

I'll tell you just very briefly where our work comes from. In 2005, I was a newly licensed child psychologist in the Bronx and I was working in early childhood mental health clinics,

specifically with children versified who have been exposed to trauma. I was referred a family with multiple siblings. I was referred the two youngest siblings, who were both under the age of two, and their seven year old sibling had been killed by their stepfather. I worked with these two youngsters who were, again, under the age of two, and was consistently heartbroken by the fact that by all the evidence I had in front of me, whether it was their behavior or their development or the reports that I was receiving from ACS, every day of their early months had been characterized by some level of neglect and/or abuse. We were the first system they had seen. And that's what drives most of our work.

I focus in the field of pediatrics based on the premise that it's the one universally accessed system for all of our families. We know that the vast majority of child fatalities occur with infants under the age of one. If you remember when you had an infant under the age of one, you were mostly at your pediatrician's office. Speaking about stigma and access is also quite relevant in pediatrics. It's a universally accessed system. I'd like to say it's positively stigmatized. Cultural and ethnic backgrounds seem to almost universally embrace the idea of going to that system and bringing your children to the pediatric practice. So that's really the premise upon which our work has been started and where I've come to it personally from my experience.

I'll share with you what our system looks like today and offer some policy recommendations that may be helpful from our perspective. We have been doing this work since 2005 and we're very thrilled to see this policy statement came out of the American College of Pediatrics in 2011. It really called for the field of pediatrics to pay much more attention to this idea of toxic stress. And I'm sure the Commission has been well briefed on this idea of toxic stress. I won't go into it too deeply, but I will say that the standard response of pediatricians, and I know there are some on the Commission, was: Great. And how? We'd love to address toxic stress and we understand it and we're scientists and we understand the effects on the brain and we understands what puts children really at risk for maltreatment. How do we do this?

We're living in a system of 15-minute visits where we have about 52 things that we have to cover in those 15 minutes, so how do we really do it? But I think the point that was so critical in this policy statement and that drives much of our work is the idea that identifying children at high-risk for toxic stress is the first step in providing support for their parents and other caregivers to really function in a two generation way when we're thinking about children at risk. And again, remembering that parents are at primary care pediatrics and that seems to be the best place to find these parents.

That policy statement was largely driven by the work of Jack Shonkoff and his colleagues at Center on the Developing Child in Harvard University. He really makes this wonderful point that health in the earliest years, actually beginning with the future mother's health before she becomes pregnant, lays the groundwork for a lifetime of well-being. I really appreciated Commissioner Carrión's remarks about prevention.

As someone who has spent my career in prevention, working prenatally with families and working in those earliest years, I'm always citing this idea of well, then what about pre-prenatal, right, how do you get to the mom preconception? Well, that mom preconception was once you're two year old. And so if we think about a lifespan system of integrated behavioral health prevention work and two generation work, I think that's probably how we

get there without getting too bogged down with when do you get there. Again, with primary care, the question seems to be in order to operationalize that policy statement, is there an opportunity to identify children at risk for maltreatment within the primary care setting. If that is the one universally accessed system, is there an opportunity to identify these children at risk within this setting? And if so, how early can we identify children? Again, going back to those two young siblings that I cared for in 2005 who were both under the age of two, most people would say, great, you got them really early. For me, it was vastly too late.

And finally, what tools might be available in primary care to accomplish this function, and most specifically, the identification of children who would benefit from intervention and who are at risk of maltreatment and how should they be administered. You're familiar with the ACEs work I know, and really this idea that adverse childhood experiences then lead to social, emotional, cognitive impairment, adoption of health-risk behaviors, disease, disability, social problems, and even early death. What we're trying to focus on at Montefiore are not just treating these adverse childhood experiences, but actually preventing them. And I think that's incredibly critical.

It is much easier to prevent this from happening and to prevent the escalation up that pyramid than to treat it at any point in that pyramid. We do have effective treatment programs. It is much more efficient and efficacious to do effective prevention programs. Why? Because of all that we know about ACEs and mental health. The more ACEs you have, the more adverse childhood experiences you have, the more likely you are to have mood, anxiety, substance abuse, and impulse control disorders. Dr. Carrión made the very important point that mental health is largely a player in a lot of the child fatality cases that they are investigating. If ACEs then have this relationship with mental health, we know that parental mental health has a relationship to child maltreatment. That's a point that she made. And I really want to spend a minute here focusing in on why I think pediatrics is the place to meet parents.

In the Bronx, where the vast majority of our families have Medicaid, and the vast majority of our families are living under the poverty line and really facing very difficult lives, parents aren't seeking their own healthcare on a regular basis. But because of WIC and because of Medicaid and because of the way we've developed some of our systems, they are very consistently seeking pediatric care.

Pediatricians have long been somewhat reticent to engage with the, say, the assessment of maternal depression or the engagement of parental mental health. I'll tell you that even in our system that I consider very innovative and forward-thinking on this, it took me years of battling to convince everybody that we could treat the parents within primary care pediatrics.

The first reason I got was that adults go upstairs. Well, just pretend we didn't have an upstairs. Pretend we're like a one-room schoolhouse. Why can't I see -- or why can't we see these parents? Why can't I bring in adult psychiatry and adult psychology and see the parents within this non-stigmatized universally accessed family pediatrics. And I'm happy to tell you that now we do that universally. We do systematic screening of clinical depression, systematic screening of ACEs within the primary care pediatric setting, and offer those mental health services right there. They're individually based, at first largely focused on the

trauma, and once the parent is ready, they become dyadic and focus on that parent-child relationship.

Coverage is key. And so we can do this, but we can only do this for parents who have coverage. Our research, and I'll show you just one of the Altman slides and tell you a little bit about these large pictures of what our intervention looks like. Our research focuses on child social emotional development as our outcome of interest. We believe that's the base for mental health. That's the base for healthy choices and good development.

Much of this research comes today from the Center on the Developing Child suggesting that social emotional development is really foundational. And from healthy coaching emotional development, we get other healthy behaviors, development, and choices in children. We know that the mechanism between parental mental health and child development is more likely to be parenting behavior than it is to be genetic. And if we can work with families early enough, preconception and around that perinatal time period, we really have opportunities, I believe, to change those projections.

Our program and our intervention program that we decided to employ is Healthy Steps. Healthy Steps is an evidence-based intervention that collocates and integrates an early childhood professional within primary care pediatrics. Our system is much more mental health focused than Healthy Steps was originally designed to be. We employ licensed clinical social workers and licensed child psychologists as our subspecialists. We have universal ACEs and parental depression screenings, universal social emotional screenings, and intervention that's based on dyadic work within the primary care pediatric setting.

We conducted an evaluation of our work looking at an intervention group that received Healthy Steps and a control group that was similar to them that did not receive the Healthy Steps program, all within our Montefiore system. Again, our outcome of interest is the child's social emotional development, but we were very interested in the mother's own history of adverse childhood experiences, specifically abuse and neglect, and how the Healthy Steps program might moderate that relationship. We know from the literature that that relationship is otherwise quite strong. If mother has experienced abuse and neglect in her own childhood, there's a good likelihood that her child's development, mental health, and behavior looks at risk later on. And so I'll show you briefly what we looked at.

Control Group children, mothers with one or more ACEs, just looking at abuse and neglect and without abuse and neglect, and intervention children with mothers without abuse and neglect and with abuse and neglect. Our measurement was that social emotional settlement on the ages in question are social emotional and that's a widely used as a social emotional screening tool. A high score on this tool is bad. You want a low score. The cutoff score happens to be 59 for three year olds. And what you see in this dark blue bar is that if your mother had abuse and neglect in her own childhood and you did not receive Healthy Steps that by the age of three, your social emotional development was off the charts looking quite at risk. If you didn't receive Healthy Steps but your mother didn't have abuse and neglect in her own childhood, things looked okay. And most importantly, what happened for those families who did receive Healthy Steps.

As you can see, even for those mothers that had abuse and neglect in their own childhood, if the family received Healthy Steps, at age three, that child was well under the cutoff score of 59 and looking really much better compared to his or her peers in the other group. But importantly again, Healthy Steps didn't appear to make much of a difference for children whose mothers didn't have abuse and neglect.

To give you a sense of the size of my system at Montefiore, we have 100,000 children that we take care of every year in our primary care ambulatory unit. 35,000 of them are under the age of five. I can't offer this kind of a service to all 35,000, nor perhaps should I. So we need to decide who needs what and we need to decide it very early which families are going to most benefit from resources integrated intensive services. We made the decision that perhaps the best way to find families at risk was to address prenatally the parent's ACEs scores. So while the mother was pregnant, we assess mother and father ACEs scores and offer enrollment into this intensive Healthy Steps program accordingly.

Our current state of ACEs screening at Montefiore, we just started this over the last year, we do it universally in our primary care pediatric setting. We started it in one practice and now folded it out to three. We do it at the newborn visit. It has to have happened by the newborn visit. That's our rule. It can happen prenatally, and it must have happened by the newborn visit. We've screened just over 1,000 parent-child pairs over this last year. About almost 60 percent of our parents endorse at least one ACE. And here's what's shocking, almost 40 percent of our parents endorse at least one ACE for their newborn child. We see about a one-to-one relationship that if a child has no ACEs at the newborn, the average parental ACE score is around one. This data is about 1,000 parent-child pairs out of about 1,082 I think if I remember. The child has one ACE, the average parent ACE is about 1.5. If the child has two ACEs, the average parent ACE is about 2.5, and it seems to go up and up.

**COMMISSIONER DREYFUS:** Can you clarify something. I'm confused. So ACEs, I know that several ACEs are around abuse and neglect, but there are ACEs that are not around abuse and neglect, incarceration of a parent, suicide in the home, and yet, you seem to be using ACEs synonymously with abuse and neglect. And I'm just a little bit confused so it's hard for me to follow this when you're referring to ACEs as abuse and neglect, I don't think that's what you mean.

**DR. BRIGGS:** In our data that we published last year in 2014, we only pulled out the ACEs specific to abuse and neglect. So there are three categories of ACEs. There is abuse, neglect, and then there's household dysfunction, which is where all of those sort of things like a parent who's divorced or a parent who's been incarcerated fall into. We only looked at the abuse and neglect part of the ACEs.

**COMMISSIONER DREYFUS:** That's what I needed. Thank you.

**DR. BRIGGS:** Thank you for that clarifying question.

The policy recommendations that I could make are unfortunately mostly around payment. I say unfortunately because I know that's the hardest lever to move in some senses. But the reality of prevention work is that we have a medical system that's predicated on a diagnosis. And if we do our job right, these children never have a diagnosis. I can get paid for screening.

That's no problem. We need to move beyond screening and include payment for dyadic work, payment for prevention.

How do we do that? I think there are a couple of opportunities. One is to redefine medical necessity. I was at an Institute of Medicine meeting a couple of months ago where the director of behavioral health for Aetna shared that they were willing to perhaps pay for an infant to have a diagnosis of adjustment disorder based on being born to a mother with depression. Is that the answer, I'm not sure, but that's one of the answers. Another idea is to think of a way for a fee-for-service model and get into capitated payment rate to really reimburse differently for healthcare practices that provide behavior health staffing at seeking this level of prevention and intervention. We really believe that the way to prevent infant maltreatment and fatalities is to treat the parents and to treat the dyad and to identify them as early as possible. We believe that primary care is a singular place where they all are and it really enjoys a lack of stigma compared to some of our other systems that struggle a little bit more with that.

I'll close just by acknowledging all of the funding that we received is outside of the regular system. To give you a sense of this, Montefiore now, as of 2015, we've totally integrated behavioral healthcare across all 300,000 of our primary care patients across the lifespan. We have -- I cover the pediatric side of this and we have a team of 30 child psychiatrists, child psychologists, and licensed clinical social workers providing evidence-based treatment within the primary care setting, but they only just started funding that April 4th, 2014, I remember the day, because for nine long years before that, I was looking at trying to acquire about a million dollars a year on foundation and grant-based funding to provide these services and when we look at record stability and spread, that funding piece is going to be a very critical part of it. Thank you for your time.

**CHAIRMAN SANDERS:** Thank you. I know we have some questions, but we'll go to Dr. Diaz first and then we'll open up questions. Dr. Diaz.

**DR. DIAZ:** So good morning. I'm really excited to be here. I'm a pediatrician that specializes in adolescent health, so I'm working with teenagers for over 30 years. And everything that I have really learned that I will share with you, I basically learned from them, not from medical school. I was also part of the Accountability Panel that Commissioner Carrión mentioned, that review cases of fatality, and I did that for years. And time after time, certain things kept recurring.

I mean, these were children that were going to child protection, so obviously the theme of the children themselves having been abused, but of other things that kept coming up was the parents, the history of trauma and abuse in the parents. And the research -- there are many research opportunities, but the research has been showing more and more three risks. One is the parental substance abuse, parental depression, and parental history of child maltreatment themselves. And the other thing that kept recurring, regardless of the age of the mother at the time of the fatality, was that the mom had had a child in adolescence, and more children very closely in space, had multiple stressors, including domestic violence. So inadequate social support and lack of resources, those things kept coming up more and more.

I think that adolescents are key to the issue of maltreatment fatalities, and if we really want to prevent this issue, we need to address the needs of adolescents. Adolescent girls with a history of maltreatment are more likely to get pregnant and to have children than other teenagers that don't have such a history. And this is regardless of the economic status.

In 2009, in California, approximately 45 percent of all adolescents that have children gave a history of child maltreatment, and 21 percent had been substantiated victims and 10 percent had spent time in foster care. Adolescent mothers are more likely to experience compounding life stressors, including depression, stress, domestic violence, and substance abuse. And I mentioned those already as some of the things that kept coming up when we were reviewing the fatalities. In addition, all of these things just put the adolescent parent at greater risk for fatal maltreatment. Also, adolescent mothers are more likely to be single parents. They are more likely to be late or to receive no prenatal services, and also more likely to experience postpartum depression and other stressors compared to adult mothers. And most of them is not likely to complete high school.

The most important factor for infant mortality is multiple children born to a mom younger than 17. These children are 11 times -- not 11 percent -- 11 times more likely to end up as a child fatality. And even in mothers who are 17 to 19, they are nine times as likely to end up as a child fatality. And this is compared to mothers over 25. A major issue with adolescents is that they lack access to services. They are also very likely to be uninsured. And even the youth that I work with here and the program that I run, we serve over 11,000 teens and most of them are uninsured. These are U.S. citizens, teenagers, you know, they are documented.

And within the adolescent population, there is tremendous disparity with blacks and Latinos having lower access and being more likely to be uninsured. And those that come for services, in general -- and this is also nationwide -- adolescents that actually get services are doing so mostly for sexual and reproductive health, often to find out if they are pregnant. And 35 percent of teen parents have a second pregnancy within two years. So sexual reproductive health services provide a window of opportunity to really identify and work with young people. Teenagers get pregnant and become parents because they are engaging in sexual behaviors but do not have access to those services and the education and the supply and the tools to prevent these pregnancies.

When we look nationally, six percent of 12 graders are sexually active. Those are the youths who are in school, so it's a much larger percent of youth who are dropouts. And there's, again, tremendous disparity among sexual reproductive health. If you look to my far right, you can see that white female adolescents and Latinas really have a similar level of sexual activity, of intercourse, yet, if you look at the outcome, Latinas have more than double the amount of teen parenting than white girls. So tremendous disparity on this.

I want to go a little deeper into this maltreatment and consequences. This is part of a paper that I published. This is national representative data. This is looking at all teenagers in the U.S. who are in schools. They are in grades 3 through 12th grade, and you can see how either being sexually abused or physically abused only or combined having physical and sexual abuse really affect or impact the outcome of young people. As you can see, where it says no abuse, it's not that these people don't have issues. The line for the abuse line is the number of times more that they are likely to be either depressed or have life stress that I mentioned. So these

are things that put young people at risk. It is also true in terms of regular smoking, drinking, and substance use. And those are reasons I've associated with fatalities.

Now I want to share with you a little bit of my own research with young people here in New York City at Mt. Sinai Adolescent Health Center. So basically of the young people that I'm seeing medically, just for routine healthcare, I ask them all types of questions, including about possible abuse and neglect. And 23 percent of my patients that I'm seeing for routine medical care gave me a history of abuse, gave me a history of sexual abuse, mostly incest. And we are lucky that our program is integrated physical health, sexual and reproductive health, mental health, dental, and optical. So I'm able to have those young people connected that same day to mental health.

When we work with a trauma focus, because 70 percent of our youth have all types of trauma, so just to give you a sense, this is the young people who are being abused very early in life, the mean age of the girls when they are abused is eight, but they are ages three, four, five, and so on. The mean age of the person is 32. And the records set up with youth that I work with are mostly biological fathers. Basically every family member is represented.

We can see here that six percent of the youth had one person over time, but about one-third of them have had multiple person over time, usually one after the other, with an average of three person per young person. Seventy percent of the abuse starts and ends before these kids are even in puberty. So it's very, very early on that the abuse is happening. And when I compare the young people that gave me a history of sexual abuse to those that were not abused, we can see that the abused ones are much more likely to be depressed. They're also much more likely to be suicidal. Eighty-five percent of the youth that has been sexually abused has a history of suicidality. Forty-three percent of them has actually attempted from one to seven times.

Something to let you all know, because I know you have been going around the country listening about trauma, all these youths were sexually abused. In addition to that, six percent of them also were physically abused, 59 percent emotionally abused, and of the eight percent that have had relationships of their own, 25 percent of them were already in abusive relationships. That's like a third of the youth and relationships were already in abusive relationships. That then puts their children at risk.

And just a few -- I have a number of possible recommendations. One is that, as you all know, prevention is getting it right from the start, as we have been hearing. The way to go is to try to prevent. And also, when we have children in the child protection system, safety is the first step, but it's really about well-being and intervention. We have a unique opportunity when we have these children to really try to work through those reasons that they are there, which is abuse and neglect. We know the impact of that.

I think it is important to see adolescents, including pregnant and parenting teens, for a history of child maltreatment, depression, and substance use, which as I mentioned, the research is supporting those as major risks for child maltreatment. It's important to connect them to interventions to ensure access to services. And when they have access to services, if the providers are well-trained, these kids will be screened and we can find the history and then connect them and intervene.

I think that integration is really important because it's hard, you know, we have silos, we have a healthcare system, and it's hard for a teenager developmentally to really deal with those silos. If we haven't integrated -- like, I'm a medical doctor, I talk with my kids, I find out they have a history of abuse, so I can say to them, go and get a mental health program. We work together as a team and have that kid see the mental health person even without knowing that they are receiving mental health. So it's really integrated. And if you're not able to integrate, you need to really coordinate very closely.

And I think all services to youth should be trauma-informed. Seventy percent of the youth I work with, so the 11,000 youth that we serve, have a history of trauma of one type or another. So I think the length of the work has to be that. I also think it's important for adolescents to receive health education, including comprehensive sexuality education in school. They are engaging in this behavior. As I mentioned, six percent of 12th graders are having intercourse. So they need to have the knowledge of how to protect themselves. I think it's important for them to have access to reliable family planning methods, to also make sure the adolescents who are having babies get timely prenatal care and get screened there for the things that I mentioned, and that they have contraception right after that delivery to prevent a second pregnancy.

And also I think it's important to invest in early childhood, but to remember that whether you invest in the first thousand days or zero to three or zero to five or zero to eight, we need to invest in adolescents because adolescents has unique challenges. And in order to maintain the gains of the early investment, we need to make sure to do that.

And then in closing, I just want to -- this is a program that I run. It's very interdisciplinary. And one of the services that we have is a teen parenting program. We work really hard at teen pregnancy prevention, and after that, with our youth, even though they are nine percent poor, 92 percent kids of color that usually have a higher rate of teen pregnancy, our youth has lower teen pregnancy rates than the city, the state, and the nation. We expend \$1,000 per youth per year for all the stuff that I mentioned, but for the youth that actually present too far along in their pregnancy or want to be a parent, we have a program where we could go see them when they are carrying babies and at the same time hopefully prevent the next pregnancy, give a newborn really a chance with all the healthcare, help the teenager get back to school, because we know they do better, help them find childcare, assess the entire system, and we also do family therapy. It could be done sometimes with a grandparent just to make sure that the system is working for the young person. Thank you.

**CHAIRMAN SANDERS:** Thank you very much for both presentations. Really outstanding. I know we have a number of questions. We'll start with Commissioner Martin and then Rodriguez and Rubin.

**COMMISSIONER MARTIN:** Thank you so much ladies. Your presentations both were very informative to the Commission. I have one question for each of you. Dr. Briggs, you had mentioned one of the best ways to get a parent is maybe to go through pediatricians and pediatrician visits, and I may have missed this so I apologize if I'm asking you to repeat something, and you said one of the hopes was to at least give parents an initial mental health assessment, particularly focusing on the ACEs. How do you do that? So when a parent comes

in with their child, does the parent also sign a consent for their evaluation or not? How is that done practically? Do we have a conversation with the parent and why we want to do this or...

**DR. BRIGGS:** It's an excellent question, and just this week actually New York State Medicaid has come out with some regulations around the screening of mothers for depression and how it functions quite logistically, so does it go in the child's chart, does it go in mom's chart, et cetera, et cetera. So for that initial screening, it's considered part of a family risk screening for that infant and it goes into the infant's chart. If the mother then or the father or the grandmother or whomever the caregiver is wants to receive their own mental health services, they must become a patient of the practice if they're not already at least documented in their chart. An initial screening is part of family risk for the infant and is included in the infant's chart.

**COMMISSIONER MARTIN:** So is that a known, widespread practice amongst pediatricians?

**DR. BRIGGS:** I don't know how widespread it is amongst pediatricians. I can only speak for mine at Montefiore, but I think that there's definitely motivation and momentum behind making this be a more defined practice. There are a number of states who have really said that they will pay for this out of their state Medicaid. And the difference seems to be whether or not it goes in the child's chart or the parent's chart, and there are some logistical differences, but I think there is definitely momentum. The key has to be if you have treatment to offer. What most pediatricians are saying is that they're unwilling to do that screening for parental mental health if they don't have a treatment service to offer.

**COMMISSIONER MARTIN:** Thank you so much.

And, Dr. Diaz, you had mentioned some of the data coming out of your program and I was wondering whether or not the data is delineated by race. So can you tell whether or not those factors that you suggested are the same for black and Hispanic and Native American children or do we know the race breakdown of the data that you've provided for us?

**DR. DIAZ:** The research that I'm doing in the clinic is based on the patients that I see and the young people are nine percent African American and Latino. And the proportion of those two groups is basically equal, like about 45, 47 percent of each. So that's the data that I'm getting, the data of the research reflects the kids that I'm seeing.

**COMMISSIONER MARTIN:** Just so I understand, when you say that children or adolescents who experience suicidal tendencies and the ones that attempt, you said something about they attempt from one to seven times. That would then be true for both of those populations, the blacks and the Native Americans?

**DR. DIAZ:** The blacks and the Latinos.

**COMMISSIONER MARTIN:** Latinos. I apologize. Thank you so very.

**CHAIRMAN SANDERS:** Commissioner Rodriguez.

**COMMISSIONER RODRIGUEZ:** Thank you so much for both of your presentations. So I want to react first to some of the data that you shared and then I have a question for you both. I feel like since the beginning of this commission, I've been a broken record about really needing to

focus on young people who are in the foster care and the juvenile justice system, both who are parenting, and now after seeing your presentation, I realize just blanket, on reproductive health, on preparing for parenting, because sort of if we know there's any group of young people who has a high number of ACEs and who has definitively experienced abuse or neglect, it is children in youth who are in those two systems, in our juvenile justice and our foster care system. I have been shocked both in my home state and as we've gone across the country at how little focus is given to really working with youth in both systems who are parenting and trying to support them both in their reproductive sort of planning and education as well as once that train has left the station and they are parents. Many of them are disproportionately represented in those numbers of young parents around providing them the supports necessary to learn how to parent in a healthy way.

And I think part of the reason I feel so strongly about this is having grown up in foster care myself and having sort of everything structurally in place, textbook-wise, having my children in my later 20s, being able to go through higher education after exiting. I'm still every day dealing with the impacts of never having had healthy parenting and having no support system, never having that family while I was in care. My children don't have that resource. So I'm just wondering, are either of your programs focusing on targeting young people who are in those two systems, and if you are not, what is the barrier to sort of putting targeted outreach and focus for young people, and do you have any recommendations for this commission around how we can facilitate better focus on those two populations of young people who clearly all of the data is telling us they are absolutely a target for support?

**DR. DIAZ:** The population that I work with actually includes many youth in foster care. We are citywide. Everyone can come to us. We make it really easy for the youth to come. They can make an appointment. They can walk in. We don't charge at all. So it's really, really a system that is easy and we serve a lot of foster care youth. We go from age 10 to 24 actually. And I myself was providing services to youth that had been in the juvenile justice system. They had completed time for whatever and they were back and it was an aftercare program and they do have tremendous needs. And something that often they have learning disabilities and things like that. And in our program, we are able to do the whole psychological evaluation trying to find the right school for them. We have lawyers who go and advocate for them.

I think it's a population that has a lot of needs, and one of my recommendations is to try to connect the youth in foster care, you know, it's great when the system itself can give them the services that I think are mentally appropriate. This is not about a medical approach, that's not what teenagers in general need, much less traumatized teenagers, it has to be a developmentally appropriate way of working with youth that also look at all other behaviors, and it's non-judgmental. You want them to really share with you what it is that they are up to and then use that to create an individualized prevention for that youth. So it's great when the system itself can provide that. If not, it would be great to connect those youth to people that can do that work.

**DR. BRIGGS:** I think Dr. Diaz responded very comprehensively. All that I would add to that is that we really try to think about meeting the children where they are. And what we have found in our data is that most adolescent children are not at the pediatrician as often as the one year olds and two year olds. It's not how they need their pediatric visits. However, they're in school. Montefiore is the largest school-based health system in the country. We have

reproductive health, mental health, dental, and physical health within our school-based health centers all around the Bronx. And that seems to be the best opportunity to interface with children in the context where they are and provide some of these services.

**COMMISSIONER RODRIGUEZ:** I agree. I just want to also say though that we know where these children are. In contrast to other children, they're in our licensed foster care homes; they are in our detention facilities; they are in residential care, so we have a particular level of access and control and opportunity to intervene in a way that we don't have with any other population, which is part of the reason that I feel like it's just an incredible missed opportunity to really target services and to go to them where they are apt to make sure they get what they need.

**CHAIRMAN SANDERS:** I'm going to take one more question right now from Commissioner Rubin and then I'm going to ask our next speaker to come up because he's going to talk about the Children's Cabinet. He needs to leave relatively soon, but I'd like for the two speakers to stay up because there's certainly quite a bit of questions. So Commissioner Rubin, why don't you ask your question and I'm going to ask Deputy Mayor Buery to come on up.

**COMMISSIONER RUBIN:** I will start by saying as a pediatrician, I feel like a kid in a candy store right now. I can have you two guys up here and take the afternoon off and you can come sit in my seat. With these terrific presentations, I feel like I've got homework for you guys because you're getting close to where we need to be in terms of recommendations. When I think about, you're doctors, a doctor of teen parenting programs, a doctor of how to really re-institutionalize bases and really provide treatment and dyadic therapy. Behind that, and if I try to build that or try to do that at the Children's Hospital in Philadelphia, and I'm thinking about going in there and doing a dual generation perspective, I start unpacking that, the people I talk to, our leadership, is going to argue and say, well, how are we paying for this.

And so you have direct experience, whether it's you or your business administrators over at Montefiore or at your program as well too, direct experience in negotiating with CMS program because it's this monolith, CMS is a monolith which we need specific recommendations, what can state Medicaid programs do to make your program whole and incentivize other places that don't yet have these programs? So it's both on the screening and treatment side and then what can CMS at the federal level do? So if I came back into the folks at your institution or you guys are doing a little bit more work with us around specificity or even providing contacts in the New York State Medicaid Program to talk about how they visualized this with you guys, that would be terrific. So I'll let you comment. Walk me through the money.

**DR. BRIGGS:** Where to begin, always with the money. I'll offer two responses to that. One, just quite specific and one that I'm most excited about and I think is possibly the direction that we're going to try to go. My colleagues in Massachusetts in the Massachusetts Medicaid office have looked at a three-tiered system for payment. They based it off of the NCQA PCMH standard. And essentially what they're suggesting is that the base level of payment is capitated per member per month payment if you're just Level 3 PCMH. If you're Level 3 PCMH, plus a social worker, let's say with a certain menu of services, then that per member per month payment goes up a bit.

If you're Level 3 PCMH plus the brochure for psychologist and psychiatrist and you have an even more comprehensive menu of services, that per member per month payment goes up even more. That's exciting to me and I think that it speaks to an accountable care organization full risk way of paying for this. The reason that we can be early doctors at Montefiore is because we're one of the pioneer ACOs whose practice is population, and I'll be 100 percent honest with you, it's a cost savings in our integrated care on the adult side that funds much of our work on the pediatric side. And we're a very large system and so we can leverage that.

**CHAIRMAN SANDERS:** So I'm going to just for a brief minute interrupt the healthcare presentation and go to Deputy Buery because we've heard about the Children's Cabinet, and I know you need to leave and I really appreciate you spending the time today. Why don't we turn it over to you and then ask everybody to stay up so we can ask more questions.

**RICHARD BUERY:** Sure. Good morning, everybody. Thank you for having me and sorry to interrupt the flow of the presentation. I want to thank both of you, Dr. Briggs and Dr. Diaz, especially Dr. Diaz who is a really dear friend and mentor of mine. And so it's great to share the stage with you and thank you for all of your leadership in the health and safety of adolescents.

So my name is Richard Buery. I'm the Deputy Mayor of the Strategic Policy Initiatives in the City of New York, and I also chair the New York City Children's Cabinet. This is Mayor de Blasio's multi-meetings initiative to increase communications, collaboration, coordination among city agencies serving children and families. The cabinet is comprised of 24 agencies focused on developing a holistic approach to child safety and well-being. They were formed in April of 2014 recognizing that the responsibility of ensuring our children's safety does not fall on only one agency but indeed on the entire city.

Together, we began to identify ways in which all city agencies can work more effectively together in making New York City the best city for children. Mayor de Blasio was inspired to create the Children's Cabinet after the tragic death of Myls Dobson, a four year old child who was murdered by his father's girlfriend earlier that year. Myls was under court-ordered supervision by the Administration for Children's Services after being removed from his mother's home in 2012 and placed with his father. ACS had visited Myls' new home I believe eight to nine times. And in these visits, the ACS staff were told that his father was at work, but by December of 2013, Myls' father was not at work, he was in prison. And tragically, his father's new girlfriend was abusing Myls. She beat and burned him with cigarettes for close to eight weeks and finally she killed him. Myls' short life and heartbreaking death made one thing crystal clear, when it comes to coordination between government agencies serving families around the community, the stakes are literally life and death.

Mayor de Blasio outlined divisions of the city agencies to work cohesively to collaborate and to communicate systematically. And he created the Children's Cabinet as one vehicle to help make sure that happens. So we started by deciding who to include. Of course we began with agencies for whom children are essential to their mission. So we've included agencies such as the Administration for Children's Services, Department of Education, Human Resource Administration, Department of Youth and Community Development, and the Mayor's Office to Combat Domestic Violence, as well as the Department of Health and Mental Hygiene.

It also includes agencies that we might not think of as children's agencies but that play a critical role in the health and safety of children. These include places like the police department, fire department, the probation department, the housing authority. We also include key agencies that work on policy and evaluation, such as the Mayor's Office of Operations, the Center for Economic Opportunity, and the New York City Center for Innovation through Data Intelligence. And finally, we included city organizations that have the unique ability to improve the environment and the culture and the sense of community in the neighborhoods in which our children live. Organizations such as the Department of Cultural Affairs, New York City Service and The Parks Department. First Lady, Chirlane McCray, also serves on the cabinet in helping to guide our work.

Given the high level leadership and resources of the 24 agencies in this cabinet, it gives us a really unique opportunity to improve the trajectory of our youngest New Yorkers. Of course the Children's Cabinet is not unique to New York or to the United States. In developing the cabinet, we've looked to models across the country to inform our structure in our first year. We had leaders such as Zeinab Chahine, Melissa Baker, and the Casey Family Programs as our partners in our work. I would like to take this opportunity to publically thank them for their close, close work in our efforts. And I'm pleased to see that Dr. Sanders is part of the Commission and so I really want to thank Casey for being a real partner with us, really every step of the way that we've tried to figure out how to take advantage of this opportunity.

So with Casey's help, we developed a framework based on three focus areas of the cabinet. The first is aligning policy and practice. Too often, agencies work in vertical silos setting goals and standards based on their organization's needs, but of course, children's lives aren't lived vertically, but they are lived horizontally. You can't focus on the child's physical health without considering her cognitive development. You cannot focus on their emotional life without considering her physical environment. You cannot separate the needs of a child's heart from her mind or her body. It's in this spirit that the agencies on the cabinet have tried to develop shared policies and practices, at least in our power, to support the city's most vulnerable children and families.

Together, agencies work the service areas where policies unintentionally work at cross purposes or where roles established by one agency are not necessarily in line with the roles established by another. So when we service those priorities and then create an environment where the commissioners and their staff can begin to work through problems whereby choosing those who are benefiting our clients ensuring the policies are aligned with use barriers to service, but also provides consistent messages to families and allows services to build off one another in a way that maximizes public dollars.

One example is the Department of Homeless Services. Regulations require that when a family presents itself for shelter, the whole family is there. They make sure that there are enough people to justify the size of the housing, but that policy can in various ways conflict with the policies of other agencies. ACS's Commissioner Carrión offered this very powerful example of a family that was living in unsafe housing and ACS told the family that the children could not safely reside in their current environment.

So the family then needed to go to the intake center for the Department of Homeless Services. The challenge with that is the daughter had a regions exam, which they didn't want

the daughter to miss the regions exam. The father also couldn't afford to take the day off of work. The result of that was two members of the family were not there for intake, which meant that the family could not be given adequate public shelter.

These are examples of the kind of issues that this cabinet creates an opportunity to have at least a place where we can service these problems and it's a place where folks can work to try to address those problems. Looking forward, the cabinet will be working to develop the city's comprehensive issues for childhood safety and well-being conversely in the process. The idea that we can integrate and align various amends from education, health and safety, family life, and social development, and produce a comprehensive framework that shows how all these domains fit together to really articulate for the first time in the city what is a milestone we want your children to achieve each day of their lives across each of these mountains. The hope is that by creating a framework like this, it will allow us as a city to better ensure that the program development is in line and make sure that financial resources are in line and that our investment in children is coordinated and comprehensive.

The second focus area is data. Data integration analytical tools. We have to expand and improve the structures that allow agencies to share data in order to identify client needs and coordinate services. In the Myles Dobson case, for example, the lack of information available to the ACS caseworkers really affected their ability to do their job effectively. So one thing that we've done was to expand the Worker Connect.

Worker Connect is a tool that allows social service agencies to share data around clients, around shared clients. We basically, at the cabinet meetings, have asked agencies to come to that meeting with their wish list. So for the Department of Education, what is it that you wish you had from the Department of Homeless Services about children in your schools who might be homeless or what did ACS wish it had from the Health Department. And then we worked with the Mayor's Office of Operations, the agency that supervises Worker Connect, to develop new data sharing agreements between agencies while ensuring that we are effectively navigating the privacy regulations.

For example, in November of 2014, we implemented a pilot in two schools in the Bronx where for the first time, school administrators of those two schools will have access to critical information about students and families from the Human Resource Administration, ACS, Homeless Services, and NYCHA to help address truancy issues and connect families who needed resources. This is the first time that schools have had access to that kind of data in realtime, and based on the initial success, we will be expanding that pilot to several additional schools that participate in the city's community school initiative.

Another example that we have recently established is a data sharing agreement that will allow the city to automatically trigger an alert whenever anyone from foster care leaves or discharges themselves from care later ends up in the shelter system. There's more than 900 young people, ages 18 to 21, who discharge themselves from foster care each year and a rough estimate pointing to about fourteen percent of them eventually ending up homeless.

So the alert that is triggered is designed to give ACS better information to prepare for independence in aftercare so that we can do a better job of connecting those children to housing services. The work around data and data sharing is constantly changing as technology

gives us new tools. At the same time, we're looking to ensure that all of our work is done in the context of privacy laws.

Looking forward, we are working with the Mayor's Office of Operations around developing more robust data sharing tools, involving even more agencies and providing even more realtime data to the front-line staff. The focus area really is program development. So really looking at the opportunity to bring all these agencies together, think about, what are the new initiatives that we can do together.

Our first big effort in this regard is our city's Talk To Your Baby campaign. Research shows that talking, reading, and singing to infants and toddlers plays a significant role in brain development. Hearing lots of words, including new, unique words early in life encourages nuance and it's an access to grow. In the data, and toddlers that are exposed to lots of words develop larger vocabularies and do better in school than children who do not. In addition to this important brain development, all the talking and reading and singing can help parents establish a strong bond with their children and sets the foundation for strong families. To support families and promote children's well-being, the cabinet partnered with the Clinton Foundation and Sesame Street, as well as Scholastic, and developed a Talk To Your Baby public awareness campaign.

First let me go on to say we worked with Scholastic to design and edit an original hard cover baby book called *Love Is*. Through various city agencies Scholastic has donated 200,000 copies of that book in English and Spanish to families with children, say, zero to three through libraries, through hospitals, through ACS centers. And Scholastic also additionally gave additional books as part of a package to go with that information, as well as information from the Clinton Foundation.

There's also a public awareness campaign. So there are ads that you can see on buses and subways and on the web and in taxis again encouraging families to talk to or read to your kids, wherever you are. Parents can also sign up for a text messaging service that offers regular texts and reminders on how to talk, sing, and play with your baby and why it's so important. The initiative of the public information campaign, the agencies like ACS and DOHMH, our health department, are coordinating the programs and services to see what are the ways they can collaborate more effectively for children, particularly at the early ages, from prenatal programs to parent coaching to parent-child intervention services. The Children's Cabinet has created a forum to have agencies come together and figure out how their programs can work together.

One of the problems they are seeing are in neighborhoods where we are in particular investing great resources that right now are happy and aside each other but not with each other. These are some of the three areas of work that the Children's Cabinet have engaged in so far. I've spent one year, and I think it's been a productive year, but we know that we have a lot more work to do moving forward. I think one of the most important things that we have done with this cabinet is simply to create this forum where commissioners come together on a regular basis to build relationships, solve problems together, build incentives together and dream together and develop a real sense of mission. I think we really drilled in the practice of collaboration.

As we move into our second year, we continue to develop exciting new initiatives. We look forward to sharing what we learned in that work with you, and more importantly, as you continue to do your work around the country, we really look forward to hearing how other cities are approaching the challenge of collaboration of the agencies that work with children to better reform our practice. Mayor de Blasio and I look forward to continued dialogue with you and to continued exchange of ideas and best practices.

**CHAIRMAN SANDERS:** Thank you. And Deputy Mayor, I think -- do you have any time for questions or do you need to leave?

**RICHARD BUERY:** I'm already late, so why not keep going. We can certainly have time for a couple of questions.

**CHAIRMAN SANDERS:** So I interrupted Commissioner Rubin. I think you also had a question and then Commissioner Dreyfus and then we'll go to the questions for the doctors.

**COMMISSIONER RUBIN:** Yes. Thank you very much. I think one of the things we've considered as we're trying to develop higher level of accountability is how we can incentivize communities, states, and even our own federal government to basically create this level of collaboration and accountability at a much higher level than just residing within child protective services. So this is the first time we're hearing about a cabinet like this. Maybe after you could forward us some of that background research you did on other cabinets. But here's my fundamental question, we see a lot of these sort of inner agency groups that come together, and I don't know how frequently your cabinet is meeting, but how do you create -- not just the fact that you're talking -- but how do you create accountability in that structure? Have you guys thought about that?

**RICHARD BUERY:** We have. One level of course starts with leadership, and frankly, the most important drive we have for accountability is the Mayor and the First Lady's personal involvement. And so the fact of that I am reporting back to the Mayor regularly about the work of the cabinet becomes the most important level for accountability. So frankly, nothing more matters than that, than having a mayor who actually cares about the work.

As we move forward, part of what we're thinking about is the alignment between the work that the cabinet does and how we spend money. Because in other words, you incentivize all of our city agencies of course is for the budget feedback here. And so doing the work of actually aligning everyone's priorities and strategies on paper then create the framework so that the Mayor and officer managing the budget and the advisors can use to assess essentially whether spending or programs are being proposed by individual agencies are actually aligned with that broader vision.

So that creates an incentive to make sure that you're contributing to the process of defining what our shared priorities are, because that's the only way to make sure that your agency vision or whatever department you are is going to be reflected and that the rules are going to be, even just to decide where you are investing resources. And if you look at some other countries, and Sweden in particular, it seems that that connection between better alignment of policy of how dollars get spent, you can see how they incentivize individual agencies.

**CHAIRMAN SANDERS:** Commissioner Dreyfus.

**COMMISSIONER DREYFUS:** First I want to thank you for talking about Myls. I have to say I was on the plane yesterday and our staff did a great job of preparing us for these meetings, and his story was told and I literally found myself crying. It's absolutely a horrific story. And I really appreciate that you honored his life by calling him by his name. So thank you for that. I have one question, and you talked about data integration and analytics, and as a federal commission, obviously we're trying to figure out what needs to happen at a federal level to support the right things happening on the ground. As you're doing this work, are you identifying where there are federal barriers to your ability to integrate data where you're having to work around some federal things, can you be more specific to the Commission?

**RICHARD BUERY:** Absolutely. And it's not surprising, I mean, very well-intentioned effective federal privacy laws constantly create limitations in our ability to do things that are common sense. So things like HIPAA and FERPA, very important rules relating to the privacy of young people in foster care.

A lot of the work involves basically lawyers spending a lot of time together figuring out, can we accomplish what the Commission wants to do within in the confines of law. I would say that remains a significant burden. It's not all federal law, it's state law as well. One of the things that the city has tried to do, again in honor of Myls Dobson, is to create a legislative package of state documents looking at some of the legal barriers that affect our ability to drive collaboration at the city level.

So for example, one law that we submitted would allow ACS and Family Court to have access to the criminal records of adults who either live with or potentially live with a child in Family Court custody and that will pass the sentiment of that passed the assembly, again, I think for very real reasons, wanting to protect the rights of criminal defendants and those who are accused.

So the challenge to us is frequently how do we balance very real and very meaning civil liberties protection on the one hand with the need for a city to have a coordinated response. And it's not just here. You experience it all over the place, homeless services, criminal justice, but we certainly experience it when it comes to aligning of policies for children.

**COMMISSIONER DREYFUS:** Thank you.

**CHAIRMAN SANDERS:** And one more question for the Deputy Mayor. Commissioner Martin.

**COMMISSIONER MARTIN:** Again, thank you so very much for your comments this morning. You've been very politic in your remarks and I think you touched on my question in your last answer. As the presiding judge of a large jurisdiction, my question is, are you also including the court? You've indicated you're including the legislature, you're the executive branch, and so I am very much interested in whether or not you're including the court just within these policy conversations that the court likewise can develop priorities around and see whether or not there are opportunities to work with the court and legislation on a regular basis?

**RICHARD BUERY:** Absolutely. Most of our legislative efforts include collaboration with the Family Court. The entire package of bills of the community try to address the challenges that create tragedies or the opportunities for tragedies such as Myls Dobson's death. So another bill, for example, is one that will clarify that non-responding parents living with children

involved in the life of children are nonetheless subject to Family Court orders. So again, that is a law that actually has passed through the state legislator here before the governor. That's another example I have, but those are the things that we've developed in collaboration with the Family Courts to ensure that, again, the Family Courts judges have the tools that they need in order to do the best job to keep children safe on sort of their watch.

**COMMISSIONER MARTIN:** Thank you.

**RICHARD BUERY:** Thank you so much. And, again, I really look forward to hearing more about your work.

**CHAIRMAN SANDERS:** Thank you so much. And so we have some questions I know for the two doctors. Commissioner Petit.

**DR. DIAZ:** I just would like to add something about the financing that is important for teens. One is that the families that we work with even when they are eligible, sometimes it's hard for them to produce the documentation to be able to enroll in Medicaid.

Then with teenagers in general, confidentiality is usually an issue. They need service, like especially for sexual reproductive health, even if they have a private insurance, the insurance company may send home explanation of benefits usually to the person that owns the policy. So some teenagers will not go for the services because they are worried about that. And often also, even though adolescents have a right to get services in every single state, especially around sexual and reproductive health, the way that they can get health insurance is by the parents enrolling them.

So in 2002, New York State got an 1115 Waiver to create a startup for Medicaid Family Planning Benefits. And in that one, the teenagers are able to go by themselves, but even with that, they are often not able to bring the documentation and the social security number. So because of that, we have continued to work with the state, and through Medicaid, we designed -- New York State now has something called Presumptive Eligibility for Medicaid for young people, especially for family planning methods.

But I think that we need to state and cut down on issues of adolescents and confidentiality and the fact that it's hard for them to get the insurance that they need, because I'm worried that they are going to become the uninsured with undocumented because sometimes we don't understand the nuances of adolescent confidentiality and how strongly they feel about that and that they will not come for the services they need because of those issues.

**COMMISSIONER RUBIN:** Let me just ask you if you could find out through your own organization if there are folks that, in the state Medicaid program, that work with the organizations around both of these issues that we can backtrack through and really ask about the relationship at the state level and also at the federal level on this later, that would be tremendously helpful.

**CHAIRMAN SANDERS:** Commissioner Petit.

**COMMISSIONER PETIT:** I have a question for the two doctors, but actually to everybody in the room, first, I'll appreciate your comments first on this thing. There's a vast body of knowledge about healthy human growth and development. And that's what you guys are addressing. It's

what we hear all across the country. And one of the things that I've learned had recourse by us going across the country holding all the hearings that we have is that this vast body of knowledge exists locally. This vast body of knowledge is held by a lot of bright people and that we're hearing similar themes all across the country.

What we haven't seen yet is that this knowledge that we have that's been documented in numerous ways, in courts, studies, et cetera, that you all have and elsewhere has not done enough to move our political system in a direction of supporting the kind of things that you're talking about. So what we have at this point are politicians at a federal level and in many states that are actually cutting the things that we're talking about today saying that we need more of.

So our commission have -- those of us that helped create the environment in Congress that causes it to adopt legislation and created this commission made a calculated decision to say, we don't want a commission to propose the elimination of child abuse and neglect, we want them to address the question of abuse neglect fatalities. And that's a political media purpose as well is that it's hard to get much press about prevention and about programs that work, and every day we have headlines screaming from across the country on these terrible deaths occurring to children consistently.

So the question that I'm really posing, and it's the question this commission as a whole has but I'm posing to you guys and to anyone else in this epicenter of a lot of knowledge about all these kinds of things here in New York City is, do we know that any of these interventions that we're talking about will actually result in fewer children being killed?

Now we know that in the end, the only way you're going to address mortality issues is to reduce and address morbidity issues. That's what we keep hearing. That's what you're saying we're seeing by this teen pregnancy issue and on and on and on. There are morbidity issues, but the morbidity issues are not moving this issue forward. So I'm still staying with this mortality question, can we show -- you have you said 100,000 children that come into your facility. As it turns out, the calculation on deaths for child fatalities per 100,000 and the national set average is about two per 100,000 children.

Do we know what it is at your facility? Do you lose two children a year? Do you lose six children a year? Were you losing 10 and now you're losing one? Do we possess, any of us, research-based information that says, there is a direct relationship between these kinds of interventions and children not being killed, not being just neglected but not being killed? Do we know that? We've been looking. I've been looking. I don't hear it.

And I'm wondering if you guys yourselves know or if people in this room know or what would it take to research that question and show that there is a relationship? Because if we don't do that, I don't believe the system is going to move politically because we've been talking for years and decades about the importance of early intervention and home visiting programs, yada, yada. I mean, we know. That's an established fact. Can we take it beyond that?

**DR. BRIGGS:** I very much appreciate your question. And I don't have the answer to your specific question about rates per our 100,000 children, but I can certainly look into that and then we can look at the metrics. We have more children than that in our larger system, so we can even probably get a better sense. I do believe there's a strong evidence base that parents

who suffer from poor mental health are more likely to murder their children than parents who do not suffer from poor mental health. We also have very good evidence on how to treat what is evidence-based mental health treatment, and to me it comes down to breaking down those silos and actually getting those parents in mental health treatment. They're not going to the community mental health clinics. And if they do go, they're not going back. And if they do go back, we're not sure they are getting evidence-based treatment. And we have to change that, because that's, to me, where the data is quite clear.

**COMMISSIONER PETIT:** It may require a study of an unprecedented level nationally because the numbers are so small. When you're talking about two per 100,000. If it's four the next week, you say it's a 100 percent increase, is it terrible or is it just a random outlier kind of situation. And I'm not familiar with whether there's been a national look at this thing from a recent point of view. I haven't seen anything on this. Teri, you might know better than anyone.

**COMMISSIONER COVINGTON:** No.

**CHAIRMAN SANDERS:** Commissioner Zimmerman had a question.

**COMMISSIONER ZIMMERMAN:** I feel like I'm going off topic. But first of all, thank you very, very much for your presentations. They were really incredibly informative and just, I think, got all of our collective juices just thinking about it. As I said at the beginning of this, I'm an American Indian. I was raised on a reservation in Montana. And so for two thirds or three quarters of American Indian and Native American people are served in primary care settings in the context of needing health services or at a clinic or the emergency department or whatever it is. So this idea of being able to really lock in on primary care as the source of some of the ways to screen for trauma and early intervention strategies around early pregnancy, post pregnancy, early childhood development, all of that is very exciting to me as you talk about this issue. But one of the other issues around fatalities and suicides, particularly in Indians actually, so we're seven times more likely, five in 15 to die by suicide between the ages of 15 to 21 if we're a male than any other of all the other races combined in this country.

So I'm wondering, and there's also been a very public New York Times article about a particular reservation in the United States experiencing a suicide cluster and talking to the media about sexual abuse as the sort of the underlying reason for it. And so Dr. Diaz, when you talked about the children or the adolescents that you're screening are one in seven suicides is because of the sexual abuse, do you have any other research, either one of you, around sexual abuse as a critical risk factor for later adolescent attempts? And the reason I'm asking is because I was called on and asked that question by a federal agency that's trying to address this suicide on this reservation about research in the Indian Country, and as far as I know, it doesn't exist. But it also just doesn't really exist around sexual abuse. Can you comment on that? I don't know if there's a question there, but just what are the linkages? Do you have any other even anecdotal information that you can share about why it's such a risk factor for suicide?

**DR. DIAZ:** I can say that sexually abused youth with similar, same demographics and everything else, but who have said they had not been sexually abused, and I think what

happens is that the teenagers get really depressed. Children are emotional. The sexual abuse is an injury. And if it happens early, it really interrupts the development of the child. It's really something toxic, not just emotionally but psychologically and biologically.

There is all type of research showing the changes. And I think what happens is, you know, we as human beings are sort of created, our bodies are created that if there is a danger regarding the jungle or wherever you are, there is a tiger to react and you run and you go to safety, but when the tiger is your daddy at home every night and you're one little child, you have no place to run. And this is a constant injury emotionally, but it changes your biology. Your cortisol, everything has changed.

And also just the emotional thing of being abused or being different than other kids and that the people who are supposed to protect you are the people who are harming you, you get into this despair and depression. And sometimes you take substances to numb that pain because it's really hard for you to relate and connect because you don't trust people. So all that makes these young people feel isolated, and numb, and different, and sometimes they just see no hope. And the reason that I think it's so important to identify them early is that then you can connect them to services. We do all type of, like, group therapy and individual therapy, and family therapy, and then connect them. And our center becomes a place that they feel safe. So I think some of those dynamics are a part of it.

**DR. BRIGGS:** I think your question asking for data on this is quite right. I don't have it but I'm happy to connect you to -- we have an adolescent suicide resource program at Montefiore that is specifically dedicated to adolescent suicide and I'm happy to reach out to those folks who probably have a much better handle on it than I do.

**CHAIRMAN SANDERS:** We are going to take two quick questions and then we'll take a break. Commissioner Covington and then Commissioner Bevan.

**COMMISSIONER COVINGTON:** Thank you. This has really been illuminating and something that we have been wanting to hear for a long time since we started our work. I have a question in terms of your work, were most of the parents mothers? And how does the interaction with the mothers sort of translate to other caregivers for the child? Have you been able to measure the contagion effect in terms of healthiness? Is it the mother having better decision-making or is there actually a contagion effect that registers outcomes for kids with other caregivers?

**DR. BRIGGS:** That's a multipart question. Thank you for it. First, yes, most of the caregivers are mothers. About three quarters of births in the Bronx are to women who report that they are unmarried, single women. We have specifically worked on outreach to bring in other caregivers. Sometimes it's the father. Sometimes it's the grandmother. Sometimes it's anyone else who is presenting as a caregiver. Research has shown us that that person hasn't always been the consistent person for the next child, and so it's been difficult to measure that. What we have looked at is actually birth spacing, because of the research and data that suggests that that's really a powerful predictor. And some evidence shows that the families who go through the program do have longer spaces between subsequent births. And we are looking at -- we started this program in 2005 and we're looking at the outcomes of the siblings now in a long-term follow-up study.

**CHAIRMAN SANDERS:** Commissioner Bevan.

**COMMISSIONER BEVAN:** Two things. One is I want to echo Deputy Mayor's shout out to Melissa Baker. I worked with Melissa Baker for some 20 years, and as the grain of child welfare experts continues, I am so happy that young people like Melissa are still here because a lot of people would not last in this field for as long as she has been here and are as committed and effective as Melissa, so I just wanted to echo that. And my only question is, really fast is, you talked about getting teen mothers and children early. What is New York City doing around infancy peer plans at the hospital? Safe care of infants. It's a requirement under the Child Abuse Prevention and Treatment Act.

**DR. BRIGGS:** I'm in an outpatient ambulatory setting so I can't really answer that as an expert on the subject, but I know that it's absolutely an important initiative and I'm sure there's someone in the audience who is the expert on that answer in the hospital setting.

**CHAIRMAN SANDERS:** We'll seek an answer during the break. So one very quick question.

**COMMISSIONER PETIT:** Just a quick question, Dr. Diaz. The analogy you drew of the tigers is exactly right. The difference with these kids is that they're living at home with the person, but the idea of adults having sex with kids is uniformly understood is a criminal offense. So in the cases that you're seeing and knowing that you can go in and help her, this young woman had been violated at a young age, play it out again and again and again in terms of self-worth, et cetera, et cetera, are those the cases that you discover that someone reveals after a period of time in custody, look, there's been a sexual thing?

There's two ways to help those kids, one is removing the child from the perpetrator, CPS, and the other is removing the perpetrator from a child, the district attorney. What happens when you come across one of those cases that were referred to both places knowing that some places in the country they triage out kids that are 12, 13, fourteen years old that are being sexually abused and in some cases they actually triage them out because they are dealing with two and three year olds. What do you hear from CPS and the DA with felony offenses?

**DR. DIAZ:** What we do, we run the report or we actually report to Child Protection and then Child Protection takes it from there. We also work really hard to work with the young people to prepare them that this is going to be reported and that we think it's in their best interest to stay with us in our care and to try to include all the family members and things like that. Then we have a wonderful relationship with the District Attorney's office and sometimes they contact us about the same thing, but our route is to go to Child Protection.

**COMMISSIONER PETIT:** Do you keep data that shows what percentage of those cases that you've seen that actually get prosecuted by the DA or indicted or arrested?

**DR. DIAZ:** I don't have that data.

**COMMISSIONER PETIT:** Thank you.

**CHAIRMAN SANDERS:** Thank you very much. That was informative. We are going to take a break for 15 minutes. We'll come back with New York State Senator Daniel Squadron.

(A brief recess was taken.)

**CHAIRMAN SANDERS:** Mr. Squadron.

**DANIEL SQUADRON:** First of all, I want to thank Chairman Sanders and all the members of the Commission for having me today. I know this is your tenth of 10 hearings, so I'll try to make it a little bit interesting. I also want to thank ACS for hosting us and for all the work that they do here in my home city.

I'm a New York State senator. I represent the 26th Senate District of New York, which is lower Manhattan and parts of Brooklyn. Those of you not from New York, I represent Ellis Island, Liberty Island, both sides of the Brooklyn and Manhattan Bridges. So, yes, it is the center of the world. However, I thought we would start with something you may not have seen. Behind you is a slide of three of the most beautiful people on earth, as far as I'm concerned, that's my wife and two children. I'm also a father. I have a four and a half year old and one and a half year old. And when my wife and I had kids, it was the happiest thing we've ever done and the best thing we've ever done, but also the hardest. And my wife, as a new and expectant mother had most of, if not all, of the advantages you could hope for on this earth, other than perhaps her husband's job, everything was right.

There was not the kind of financial strain that led to choices between housing and food and medical care. There was a supportive network both within the home and beyond it. There was stability and education going back decades. It was still, as I say, the hardest and most difficult thing we've ever done. The stresses and pressure, the need to manage emotions and understand little people who can be extraordinarily difficult to understand is for two professionals who have channeled themselves throughout their lives unparalleled. Add to that, of course, additional stressors, whether it's a history of violence in the home, domestic violence or being a victim of child abuse or neglect or poverty, we know the statistics on what that does and we know that it's not some surprising statistic. We know that it comes from the fact that you take multiple stressors and that poverty or histories of being a victim of violence add stressors to you that make an extraordinarily difficult task all the more so.

This is from a professor in California who talks about some of the evidence-based consequences of poverty. You see right in the center there what this professor terms parenting quality, which I think is the core of what the Commission is charged with looking at, talking about, and preventing, not just dealing with, but preventing. So what is evidence-based? I'm not going to read it. I think we all know what it is, but I do think this is important. Evidence-based is not you know it when you see it. Evidence-based is some independent entity has done a controlled study of the impact of a program.

I used to chair the Social Services Committee in the New York State Senate and there are more worthy programs just in my home state than I could list through all of the 10 hearings. Every one of them, just about, we are better off funding than not. The number of those programs that are evidence-based though fits on this hand. We need to identify these programs because we don't have enough money, because it's not a pass that we can just throw dollars at. It's not because the other programs aren't enormously valuable. It's because as policy-makers at the state level, federal level, as experts, we need to make choices. And we should look to evidence-based ones.

Maternal home visiting. At this point, everyone knows what maternal home visiting is. In brief, it is programs that partner expectant moms with specially trained experts, hopefully starting before birth and continuing through until the child is a toddler or school age. We

know that there are a great deal of evidence-based maternal home visiting models. Here are three that the Department of Health and Human Services has essentially certified as being evidence-based in finding the research behind them compelling.

You'll also find that among the many benefits that they have, these programs do speak to the issue before this Commission, issues of child abuse and neglect, and they are three programs that we have in New York. There are other programs out there nationally, as you know. One other thing I'll get to in a moment is there are small home visiting programs and medium size home visiting programs. There aren't really huge ones, and it's not always based on how much evidence is behind them or how big they are, it's based on the fact that we haven't had a large consistent funding scheme for these programs. Over time, even they made progress in the federal government, but not enough that we kind of -- it's not a field where we sort of had the widening down to the few very good programs that are also very big.

Nurse-Family Partnership, high-risk first time moms from the first prenatal checkup, hopefully, until the child is two. Healthy Families, high-risk moms, not necessarily first time, continuing a literature bit longer based on certain milestones. Parents as Teachers continuing a little bit longer and the eligibility very similar to Healthy Families.

I want to point out, and I'll get to this in one moment, different kind of price per family per year to each of these programs. Nurse-Family Partnership in New York context is in the range of \$7,000 or so a year. Healthy Families is in the range of \$3500 or so a year. Parents As Teachers \$2600 or so a year. It's an important point that I'll come back to, but there is -- we're talking about evidence-based maternal home visiting. There are the Evidentiary Foundations Nurse-Family Partnership. They are so significant, they are illegible. And I think that's an important note, but just in the specific focus -- and by the way, that includes 15 years later a 50 percent or so reduction for both moms' and kids' likelihood of being involved in the criminal justice system. If you look at major costs for the public sector that you should be able to do something about, we've got Medicaid and health costs, you got the criminal justice cost. This impacts both.

I know the focus of this Commission is largely on specifically child abuse neglect; a 39 percent reduction for injuries in the first two years of life for children born with moms with low psychological resources; a 56 percent reduction in emergency room visits for accidents at age two; a 48 percent reduction in state-verified reports of child abuse and neglect over the first 15 years. That's Nurse-Family Partnership.

Healthy Families, nearly equally illegible, 88 percent reduction in the average number of acts of very serious physical abuse at age one; a 75 percent reduction at age two; an 80 percent reduction at age seven; 49 percent reduction of confirmed CPS reports between the fifth and seventh years of life for first-time moms who were enrolled early; thirty-three percent reduction of confirmed neglect; and 77 percent reduction of confirmed abuse for new children whose moms had CPS involvement prior to being involved with Healthy Families.

And Parents as Teachers, 50 percent reduction of suspected abuse and neglect. Children less likely to be treated for an injury. Moms less likely to be subjected to child abuse investigations. So those are three programs. This is the evidence. Don't trust me, trust the studies and partners on community services that we have in New York.

Universal Home Visiting, what does that mean? What it means is that every expectant high-risk mom gets offered a home visiting program at the time of their first neonatal visit. That doesn't exist anywhere, by the way, in this country, but that's what we're talking about. And let's talk about why that's important. We know these are evidence-based programs that make a difference. We also know the federal government with maternal and early childhood home visiting program has invested in this in an unprecedented way through the course of the last few years, but we also know that it's gone from essentially nothing to \$400 million a year.

New York State, we've increased our funding. I was able to create a Nurse-Family Partnership funding line in the state. Healthy Families has been funded for a period of time, and that was recently. But essentially, we are tiptoeing towards a solution that we know works when we should be running. The concept of universal home visiting gets us on the track so that we're no longer kind of tiptoeing along the way. By the way, New York State, I have bipartisan support for this, my co-leader is a republican. I happen to be a democrat. We served 2800 families in NFP, 5600 families in Healthy Families. We have I think 120,000 Medicaid parts a year.

So any evidence-based home visiting program that would be found eligible is what I mean by universal maternal home visiting program and when I mean universal to start eligibility Medicaid births talk about eligibility and we think 50 percent uptake would be a great place to go. We think that that's probably an ambitious reflection of what universal is. Remember, if we're offering it at the earliest prenatal visit, we have an almost universal offering process. It's almost universal that an expectant mom will at some point see a medical provider sometime between pregnancies, the time that they learn they're pregnant, and birth. So the idea of universal access is real in this.

How much does this cost? This is New York State, 60,000 annual enrollees, that's 50 percent I'm going to say are Medicaid births. Right now we spend about 43 million between Nurse-Family Partnership and Healthy Families. That's the lion's share of our state funding. So we're talking about a quarter billion new dollars in state funding at the point that we are fully wrapped up. By the way, we couldn't do this in New York State next year. We don't have the capacity. These programs would have to build in capacity over a number of years. Let's not forget, I know the Commission is highly familiar with this, the return on investment from a simple budgetary perspective of these evidence-based maternal home visiting programs is extraordinary. A lot of that savings comes in Medicaid, certainly in the early years, comes in criminal justice, and some other mental health and other services over time. But it's significant.

And by the way, as I've heard and gotten reports on spaces between kids, all of the underlying issues you're hearing about, every one of them go back to those evidentiary foundations. Take out a magnifying glass, you'll see just about every one of those is impacted here. So we happen to know why these work in addition to knowing they do work. It's a big investment to go from \$50 million to \$250 million in the context of just one state. At any amount of total spending when you look at our healthcare costs or our criminal justice costs or the cost in the lives of child abuse and neglect that I know you've spent a lot of time on, how do we pay for this? I'm going to start from the middle here and work up. State-level funding, the state could do it.

In New York State, we have a bipartisan group of senators and assembly members. To give you context, we have a 63 member house in the senate, a bipartisan division of 27. Both parties have signed on for the concept of universal home visiting in New York, including a dollar amount of \$100 million in new funding, 32 assembly members, now we all signed on to that. To be clear, we didn't end up with that this past budget cycle, which is an interesting thing. One interesting thing about these programs is they're very popular. No one is against them. Sometimes that hurts politically. There's no boogeyman here. There's no existing structure that needs to be torn down.

Child protection agencies, child welfare agencies are doing what they can with what they are facing. This is not about replacing something we have, it's about preventing something we have. And from a political point of view, it's harder to get a hold often. State level funding is one way to do it. I think the federal government can do it. It has stepped up in a huge way, based on history, with the maternal home visiting program, but, you know, the truth is we know that's stepping up in a huge way from where we started and it's hard to get where we need to go with sort of programs that are in the public eye smaller and less focused.

Medicaid is appropriate for this. New York State applied for a Medicaid waiver to have Nurse-Family Partnership, and I believe Healthy Families, be eligible for Medicaid. We were approved in New York State for what we call district funding for sort of the transitional funding as we move our healthcare models from a hospital based model to an outpatient preventative model, but it is not categorically eligible for Medicaid in New York. We were denied that request in New York. Categorical eligibility for Medicaid would achieve universal eligibility in the very short term.

**COMMISSIONER RUBIN:** Can you in fact answer us why?

**DANIEL SQUADRON:** Why?

**COMMISSIONER RUBIN:** Yeah.

**DANIEL SQUADRON:** Well, I mean, partially because we define universal eligibility as being Medicaid.

**COMMISSIONER RUBIN:** Why was Medicaid eligibility not -- why did you fail in that waiver?

**DANIEL SQUADRON:** And to be clear, New York State had a multibillion dollar waiver application with lots and lots of components, and we ended up getting multibillion dollars in additional Medicaid funding. At the end of the day, many of the requests were denied, many were accepted. This is not a big ticket request. This is not one that you'll see in any of the sort of new reporting about the application.

I don't know what CMS, what their process was in that. Certainly they validated that it was an appropriate program to get Medicaid dollars through this district program, through the transitional program. The idea of expanding categorical Medicaid eligibility to a new set of services, you all work at the federal highs, I work at state highs, my understanding is it's pretty high. And you know, that's the issue. If you look at the number here, and I think I should have in front of me the total Medicaid -- we get well more than \$10 billion a year in federal Medicaid funding in New York. So we're talking about a small increase, but it's an

increase in a whole new set of programs. There is a way to sort of soften that and sort of get us there with social impact bonds.

Social impact bonds are a way for the state, for the government, to essentially borrow against a new program that it thinks will save money. It shouldn't be done lightly. It is appropriate for governments to borrow capital dollars for physical infrastructure. I think we all agree with that. That's essentially a universal view. The idea here is, are there programs that have a social impact that is as predictable and definitive as some of the physical infrastructure that we do fund through essentially debt financing that we could finance this way. If they exist, they are evidence-based maternal home visiting. I think that everyone would agree with that.

I happen to have a number of the big banks, including Goldman Sachs, centered in my district, and I think they would tell you the same thing. Bank of America and Goldman Sachs would tell you they would love to be able to lend the government money to fund it and only get paid back if the government saves the money it thinks it will. The truth is, social impact bonds are most appropriate for experimental programs. These programs are pretty well evidence-based which means government should just go ahead and fund them. We know we're going to save money on them.

We also know that movement to fund things that have not been funded previously at the speed we should be doing to prevent child abuse and neglect to vastly expand opportunity for kids and their families is going to be hard. This might be a transitional way to do it, especially since sort of the time frame they work on, five to seven years, is exactly the time frame that you see sufficient Medicaid funding, if the federal government is involved to pay it back. Localities, not really. Even New York State, we have a mix of state and local funding for Medicaid. State can do it, but state and federal government together, you're really starting to see a better value in doing social impact bonds. To be clear, Medicaid eligibility for this tomorrow would not bankrupt Medicaid and would create national universal home visiting. The political reality is, perhaps we're not yet there. And that's the final slide.

I'm interested in taking your questions, but I do want to just sort of say again, the biggest challenge I have is how supportive everyone is of this concept. Can't get covered on things that have no enemies, that being covered it's very hard to get funding and because everyone is so clearly deeply supportive, every time there's a decision not to fund one of these programs, it's not because of some -- I say a lot of time we need some reform -- but it's not because there's some dirty deal in the backroom. It's just because we haven't been doing it in the past and the concept of the kind of expansion we need is very hard for people to get their heads around.

This Commission is in a unique position to make some of those value judgements between many things that are good and important and say, it is simply malpractice not to be doing some of them. And evidence-based maternal home visiting is one of them or whichever programs are needed for the family, which is my final point. Nurse-Family Partnership is a lot more expensive than Healthy Families, a lot more expensive than Parents as Teachers, but when you talk about return on investment, when you talk about impact on the family, every one of these programs is important.

You will never have a budget officer though who has more families at risk who they need to serve than they have money for choosing to serve a third at night just because the program has a better long-term impact. It's simply not the job of a budget officer. And frankly, when you look at the heads of these agencies, they have the same problem. They are given an insufficient budget for the challenge they face, giving a very good program to more families is almost always the choice that will get made in that context than giving a program that has even greater effect to a smaller number of families. It's really important that you have the entire array of evidence-based home visiting programs. Every one of these is the best program for some families.

**CHAIRMAN SANDERS:** Thank you very much, Senator. We have a number of questions. Commissioner Petit, then Commissioner Bevan, then Commissioner Rubin.

**COMMISSIONER PETIT:** The statistics you quoted at the beginning in terms of the impact on the reduction and reports on child abuse neglect, I want to ask a couple of questions about that. One is, what was based in terms of the size of the families, was it based on 10,000 families? 100,000 families? A million families? Do you know?

**DANIEL SQUADRON:** So it's different for each of them. I'll go from the center of my familiarity. The Nurse-Family Partnership program was based on randomized controlled trials in at least three different locations over a period of more than 35 years. And you know, each case, it is a peer-reviewed randomized control trial. I don't remember the size of each, but, you know, they're sort of the gold standard. Healthy Families is in the midst of that kind of research. New York is the center of it.

Now, some of the Healthy Families research has not been published, and therefore, not peer-reviewed because it's a state university that is taking the lead on that research. Their initial findings are dramatic and we would love to put the Commission in touch with those researchers, but there are some that are published and peer-reviewed on Healthy Families. To the extent it has, it's been well-received, but some of the statistics I cited are from non-peer-reviewed research.

**COMMISSIONER PETIT:** Thank you. What I think would also illuminate the topic is, how many children in all these programs, which we apparently know who they are, where they are, et cetera, how many children died in those households over the course of a year, two, three, four, five, 10? Not what was the reduction in reported child abuse, what was the reduction of the cases, but were any children killed when these programs were in operation when there was an active or previously active situation? Do we know? Has anybody looked at that?

**DANIEL SQUADRON:** We can certainly find out. In the case of Nurse-Family Partnership, you're talking about only first-time moms, so they wouldn't have been previous...

**COMMISSIONER PETIT:** I couldn't frame the research question myself, but the basic question is, if there's been a million families that have been involved with home visiting programs over the last 10 years, how many children died while they were involved in those programs than previously? So if you were sitting here now and presenting to the Congress and you said, listen, you know, we've had a million kids go through here, no children have died or only 10 children died, or only 50 children died, that would be a powerful thing.

**DANIEL SQUADRON:** Why don't we get you that? I do know that the Nurse-Family Partnership, those statistics are available but they're not in front of me right now. And the other programs, I'll have to find out if they're even available.

**CHAIRMAN SANDERS:** Commissioner Bevan.

**COMMISSIONER BEVAN:** I appreciate your comments about sort of the political realities and I'm wondering, can the social impact bond model, can it be applied to incremental approaches? I mean, that's what we need. We don't want it, we would love to reform the system, but politically we're not going to be able to. So an incremental approach, can you tell me what you think it would look like and do you think social impact bonds would be useful?

**DANIEL SQUADRON:** They actually can be applied in an incremental approach. The policy-makers will have to make sure they are not replacing on budget public dollars --

**COMMISSIONER BEVAN:** Supplement not supplant.

**DANIEL SQUADRON:** Right. So that's your first step. Your second question, absolutely you can come up with pilot programs in any number of ways. I do think this concept is going to reflect and actually going to Commissioner Petit's question is important because we want to see -- we want to answer questions as to whether any of this research has screening going on or anything else. So choosing a number of localities or counties in our state or across the country to provide this in a certain one incremental way to do it from the point of view of the social impact bond investor that has the same impact.

What they need is a definitive population. In the case of New York State and social impact bonds, Governor Cuomo was sort of the driving force behind the first state level program here. Randomized control trials are very important. So choosing a definitive population where you can do a randomized controlled trial is absolutely a way to do this and you are serving kids that are not getting served. So if we use New York City as a pilot, that's a great and huge starting point or Erie County in the west part of the state where they've had a child abuse sort of crisis.

**COMMISSIONER BEVAN:** I was a little confused about for the social impact bond approach, does the program -- does it -- should it be evidence-based, like, already proven evidence-based or are you saying it has to be an experimental program that doesn't have a backing to it?

**DANIEL SQUADRON:** Well, it's got to be a program that you can get private investment in. So the more evidence there is behind it, the more capital will be available, the lower the cost. At some point, and I think as policymakers we need to ask why we are going outside for a program that's already been proven, but as you pointed out, the political realities and the fact of incremental funding is one of the reasons to do it.

**COMMISSIONER BEVAN:** Okay.

**DANIEL SQUADRON:** And the more evidence you have behind the program, the cheaper it's going to be to go outside for funding.

**COMMISSIONER BEVAN:** I have a quick question. When you speak Healthy Families, because it came up before, are you speaking about a Hawaiian model or are you speaking of another program? I think Healthy Families Federal, I think of about the Hawaiian model Health and Families Preparation model, but that's not what you mean.

**DANIEL SQUADRON:** Healthy Families, which is Healthy Families New York, which is an independently run program that sort of follows this model, that we've had a great deal of state funding and support for overseeing by the state child welfare agency, and in many, many counties in New York State.

**LAURA VELEZ:** I can help you with this. Healthy Families New York is part of the Healthy Families America model.

**CHAIRMAN SANDERS:** Commissioner, we need you to be mic'd.

**LAURA VELEZ:** So Healthy Families New York is part of the Healthy Families America model. And so there's a National Healthy Families and New York has adopted that model. There's fidelity to that model. There's data that is collected nationally from New York City on this model and we also produce data. I'm actually trying to find out right now whether or not we can determine or if we have any data related to fatalities in the Healthy Families program. I can't speak for Nurse-Family Partnership because that's a Department of Health funded program.

**COMMISSIONER BEVAN:** Maybe just family preservation, family support.

**LAURA VELEZ:** I think we really consider it an early intervention. I don't know if it's called family preservation, but it's certainly -- I don't know what its catch name is.

**COMMISSIONER BEVAN:** Is the purpose to avoid foster care placement?

**LAURA VELEZ:** No. Its purpose is to prevent child abuse and neglect. Its purpose is to be a primary prevention program that prevents deeper penetration into any of the other systems. It's a primary parenting kind of program that the families get visited every week. There's teaching in the home around how to interface with your child. There are developmental milestones that are reviewed. It's fairly intensive. And it lasts -- once a family is enrolled, they can stay until the child is five. So it's a long-term commitment.

**DANIEL SQUADRON:** And a lot of child welfare in the city and state level have been supportive because it's sort of consistent with the work they do just often not on the preventive side, but after there's already a problem -- this is at the problem?

**LAURA VELEZ:** Right.

**DANIEL SQUADRON:** So the Nurse-Family Partnership model falls a little bit more closely into sort of a medical model where it's providing a lot of health advice and partnership. It's also very effective. It's also very intensive. It's visits on a weekly basis through pregnancy and every other week or every month through the time the child is two. In both cases, they talk to the providers or the clients. What they talk about is having a partnership that makes it easier to ask tough questions, that teaches them the basics, like holding their child, looking at their child.

**CHAIRMAN SANDERS:** I'm going to have to move this along. We can get some more written information on the program. We have at least one more question. We have more questions, but I'm going to limit it to one more question and then we'll move on to the next panel.  
Commissioner Rubin.

**COMMISSIONER RUBIN:** Thanks. I just -- I actually think Commissioner Petit, you were actually raising some important issues that I just want to acknowledge. Number one, I sort of see an infant death in a child that's been exposed to maybe a program as something that should be reportable and publically exposed just like hospitals disclose their centralized work. These are kind of opportunities to quality improvement to understand.

The literature -- I just want to acknowledge there is a literature emerging, Commissioner Petit, and it does show a reduction in infant mortality and I think there are several studies, including one from my own senator, that are in the pipeline right now revealing a reduction in mortality, but it's more complicated. It's a lot of these sea of neglect related deaths and supervision related deaths that conversely there may actually be a little bit of higher rate of those really sensational horrible deaths of physical homicide, like shaken babies, we're not seeing the level of impact, and some of that may be related to what we're seeing is sort of integration issues in terms of if there's no childcare opportunities in the community and you send the mom back to the school, who do you think is taking care of the baby, right.

And so there's work to be done to strengthen these laws but at the overall level, I think there is an emerging data that shows this. Now the question I have for you is, and this is my own opinion, as I think with the last panel and this panel, I believe strongly that as someone who is interested in the Medicaid program and its soon to be here that dual generation treatment at the point of pediatric care or home visiting, we should be having a discussion whether these are UPSC benefits of children. And that's my personal opinion. I'm not saying that everyone shares it on the panel, but I can tell you that that makes people uncomfortable. You get the sense and there's a history of fraud that everyone is going to start putting up a sign at the office and saying, we're now providing these services and so it feels very open-ended.

And might I suggest, I'm sort of interested in the failure to get that waiver for New York. I'm just wondering if there's an opportunity -- I know these programs don't succeed unless they're really -- and it's the same lessons we've seen with our child abuse stuff, unless they're really integrating in a public health framework of collaborative work, then maybe it's not simply that these are UPSC benefits, but that we need to define or CMS needs to define the permissive environment in which UPSC claims can be made for home -- so when home visiting is established in connection with a primary care health system that that primary care health system can bill for home visiting as opposed to just having a free-standing in a community not connected to any other services or for certain types of target populations that if it's done in the context for priority populations in residential treatment that they might be it. So I'm wondering if that's the way to kind of narrow this discussion around UPSC by actually creating some regulatory authority in the environment in which those bills can be made.

**DANIEL SQUADRON:** As a primary point, this is not a world where you want 1,000 flowers to bloom. You don't want lots of clinics and providers to come out and say this is home visiting. The evidence-based component of it is sort of a filter that I come in with today. And the fact that HHS has done so much work sort of analyzing the literature that's out there and the fact

that there's going to be both Healthy Families and Nurse-Family Partnership, you have very strong private and privately funded, but certain national service providers that are very careful with their grants and their reputation.

I do think if you look at what we've got in New York though, which is the fact that hospitals as part of transition programs, could include Nurse-Family Partnership, you're actually pointing towards two things you raised, which is you do need to have some kind of integration, you do need sort of a larger provider of medical services and recipient of Medicaid dollars to be linked for this to make sense.

It also does make some sense relative to the idea of offering universal access. And I talked in the beginning about the fact that as opposed to after the child is born and family life has started, in pregnancy and birth, you have a nearly universal recipient of medical care, but of course, if you haven't linked to those medical providers, they're not going to come in and be offering you programs and choosing between programs of vastly different costs, \$2500 to \$7500 just in New York City, whereas if they have some skin in the game, they are going to be assigning those programs more probably more officers or the heads of public agencies, but also not sort of all these most expensive programs regardless.

So I think there's a lot to suggest that. The issue in New York is we didn't get direct eligibility at all. We got 50 block grants that we could use for this. And that doesn't lead to universal access, especially when you're talking about hospitals. I mean, this is not a profit center. It's heavily intensive in terms of staffing, very, very low in terms of, you know, procedures and other things.

**CHAIRMAN SANDERS:** So we're going to have to wrap up. Thank you so much.

**COMMISSIONER DREYFUS:** Outstanding.

**CHAIRMAN SANDERS:** This has been quite an informative morning. Thank you. So I'm going to call up our next panel, which is on the New York City Safe Sleep Initiative, Dr. Barbot, Dr. McKnight, and Lorraine Stephens. And we heard earlier today that 50 percent of the fatalities in New York City are safe sleep fatalities, so this should be quite interesting. Dr. Barbot.

**DR. BARBOT:** Good morning. It's an honor to be here with you all today. I'm here along with my colleagues from ACS and DHS to talk about collaborative efforts we have taken for ensuring that all New York City babies have safe sleep. As we know, placing babies in unsafe sleep conditions is a leading cause of infant suffocation deaths in New York City. We must do all that we can to make sure that our youngest New Yorkers sleep safely every night. And we're proud to partner with multiple city agencies and community partners across New York City to create awareness to educate families and develop strategies to prevent infant fatalities.

So as a highlight of what I'll be covering today, let me just say that I'll be focusing on the data and highlighting racial disparities and infant mortality and specifically in sleep-related deaths, and also talking about reframing our messages in a public health way to really talk about injury prevention and the fact that these are preventable deaths, and stressing the importance of early education and education from multiple sectors, not just public health and healthcare delivery.

So this first slide illustrates the geographic disparities in infant mortality that we have in New York City. We don't have a similar slide for sleep-related deaths since the number is so small, but infant mortality rates track fairly consistently with what we're seeing with sleep-related deaths and the darker areas in the map are in larger also areas that have the greatest concentration of individuals who live in poverty, people of color, and parts of the city that suffer disproportionately from disparities in other chronic and acute illnesses.

And so while the citywide infant mortality rate has been trending downward for the past 20 years or so and we are at a historic low of 4.3 deaths of 1,000 live births, we still have significant gaps between black and white babies. And additionally, we haven't seen a significant change in the number of sleep-related deaths, and those disparities also persist in sleep-related deaths. So this slide demonstrates the decline in infant mortality rates and it shows that though the infant mortality rates have been decreasing, the disparities are actually getting worse and black babies are 2.8 times more likely than white babies to die early on, and that 2.8 is actually higher than the national average of 2.2.

When we look at the leading causes of death in the neonatal and post neonatal periods, we see that roughly two-thirds of the deaths are under one year of age occur in the neonatal period and most of those are the result of prematurity and low birth weight. In the post-neonatal period, we see that sleep-related injuries and suffocation are among the leading causes of death and that's the red bar there.

Shifting now to this slide, it's a graphic representation of the collaborative efforts that have been underway since 2005 between multiple city agencies and focusing on efforts in reducing sleep-related injuries. This committee was formed in 2004, and in 2005 after reviewing large amounts of data and evidence, decided to focus on reducing sleep-related deaths and so as a result of that, in addition to looking to focus on reducing disparities. And as a part of these efforts, the city joined the National Cribs for Kids program which is designed to educate parents and caregivers and distribute cribs, fact sheets, and educational materials. And this program was incorporated into our Nurse-Family Partnership and our Newborn Home Visiting Program. And since it began in 2007, there have been over 42,000 families that have received education and over 6,000 cribs that have been distributed. And I think one of the main points coming out of this effort is really the importance of standardizing messaging so that every agency that touches these families is singing off the same song book and there's consistency in the messaging that we have.

This slide here illustrates the disparities in sleep-related deaths and we see that babies born to African American women are three times more likely than Hispanic babies to suffer sleep-related deaths and five times more likely than white babies and six times more likely than Asian-Pacific Islander babies to suffer from sleep-related death. Additional characteristics of sleep-related infant injury deaths vary widely by certain demographic characteristics and what we find is that by and large, these occur to U.S. born mothers -- and I'm speaking here about New York City --- infants whose mothers have less than a high school education and infants whose mothers were under 20 years of age.

Additionally, what we found in reviewing the data was that 74 percent of the infants that succumb to sleep-related deaths were between the ages of 28 days and four months. Forty percent were sleeping on their stomach as opposed to 29 percent on their back as they should

have been. Nearly 60 percent were sleeping with excess bedding and 67 percent were sharing a bed with an adult or a child at their last sleep as compared to 28 percent that were found in a bassinet or a crib.

I'll just take this opportunity to remind all of us the ABCs of safe sleep: Alone, on the back, in a crib, period. And so part of the importance of how you carry it is not as a legal team but from a public health perspective and this being an injury prevention conversation that emphasizes the importance of consistent education that starts early, prenatally and reinforced in the early part of the pregnancy, additionally supporting families in need by providing the tools for safe sleep, engaging consumer advocacy for modeling safe sleep and fostering inter-agency collaborations so that we can continue and institutionalize consistent messaging and practices.

And so this last slide covers some of the examples of activities that have resulted as a part of our inter-agency collaboration, for example, the Office of Emergency Management has emergency supplies of cribs for families that are displaced. Additionally, ACS distributes cribs. Our Health and Hospitals Corporation, as of this month, will begin distributing cribs to families in need. And additionally, the city just allocated a significant amount of dollars to institute a newborn home visiting program for families living in shelters and so that was part of that home visiting program. They will also receive cribs. So with that, I'm going to turn it over to my colleague to continue the presentation.

**DR. McKNIGHT:** Good morning. I'm Jacqueline McKnight, the Executive Deputy Commissioner for New York City's Administration for Children Services and Child Welfare Programs. I would also like to thank the Commission for allowing New York City's participation in today's session and for providing the Administration of Children's Services, specifically Child Welfare Programs, an opportunity to address this most important topic. We do see ourselves as a key sponsor and catalyst in addressing this matter.

Being a former Brooklyn borough office commissioner, one of our larger boroughs, I saw quite often the work on the back end after the loss of a child, the trauma to the family in what appeared to be a preventable death. I would like to begin with furthering the discourse on the magnitude of New York City's Child Protection's involvement. As the commissioner referenced in her comments about the number of investigations conducted annually, I would like to focus on the number of children involved.

As you see, the investigations conducted for 2014 included nearly 85,000 children with numbers in 2010 even higher of over 93,000, whereas the number of deaths annually have been about eighty-eight. We have seen an incline in the percentage of fatalities related to our investigation with a rate of nine percent in 2010 and 12 percent of 2014. However, the number and percentage of sleep-related deaths associated to panel cases, those are our families known to the children's services has been stated to be about 50 percent.

We have however seen a slight decline this past year with a rate of 33 percent, which we would like to hypothesize is a testament to our concentrated programing efforts over the last two years, and we would like to highlight the support that we have received from the sponsorship of Casey Family Programs. Based upon the consistent trend in the number of deaths, both panel and non-panel cases, ACS has begun hiring a dedicated team of seven staff

to plan, manage, and implement our strategies, five community coordinators that work in targeted neighborhoods with high rates of unsafe sleep deaths, such as in central Brooklyn, and Morrisania, Bronx to educate families about safe sleep practices.

Our key strategy, as Dr. Barbot referenced in her presentation, we must ensure that there is a consistent safe sleep messages that are being shared. There has been a production of a 30-second public service announcement, which I will further address shortly. We have had the opportunity to learn from other jurisdictions, such as Baltimore City who has a promising -- have seen promising outcomes. We also support a court system approach, including the expansion of key stakeholders to support efforts to include the Mayor's Office to Combat Domestic Violence, Domestic Violence Deputy Chief Office, the NYPD, and domestic violence unit, Health and Hospital Corporation, provider networks, as well as other city partners, such as the agencies presenting with me this morning. With targeted outreach, we are focusing on new parents, specifically focused on childcare programs, hospital and shelters. We do see our shelter families as one of our most vulnerable populations. You will hear more from my colleague First Deputy Lorraine Stephens.

We've also crafted specialized training curriculum as well as policy and guidance on basic practices for our entire child welfare staff, not just our child protection staff, but our foster care and preventers and our providers, as well as Family Court legal service staff. And we are focused on efforts to collect and use data to continue to inform our strategies. The next several slides are samples of materials that we are utilizing to address the outreach and education efforts. The public service announcement, which had 150,000 hits, which suggest that the use of social media may be a key strategy for families we serve. These are onesies that we distributed in the past being sensitive to language and culture with our appeal is very important. And these are our seven key tips, and we've actually applied them to pom cards, magnets, as well as tote bags. And I'm going to turn it over to my colleague.

**LORRAINE STEPHENS:** Thank you. Good morning. I am First Deputy Commissioner Lorraine Stephens of the Department of Homeless Services. Thank you for having me today. I'm going to talk a little bit about homeless services.

Just a general overview, there's over 56,000 individuals who are homeless today in New York City. 11,000 of them would be families. The average household size is one to three. Eighteen percent of the individual families that are in shelter have been in shelter before as a child. The average head of household is 34. Forty-seven percent of them do not have a high school diploma. As you can see on the slides, the breakdown of the ages of children, over 40 percent of them are in the ages of zero to five.

Just last year alone, 1800 children were born into shelter and about 24 percent of them have an open child welfare case. This slide represents the number of deaths of children in homeless shelters. As you can see with the blue bar, there's four in calendar year 2015 have died of either natural causes or safe sleep. In 2014, that would be the same. In 2013, we had our highest number of eight children under the age of five. Last year alone we asked ourselves, how can we strengthen child safety in shelters?

The first thing we needed to do is understand the families that are in shelter and their child welfare involvement. We looked at over 2,000 cases and did a case record review with ACS to

really see where those families were and what services they needed. One of the things we understood very quickly was those families that had ACS involvement were considered high-risk and we needed to work with them very differently. We work very closely with actually developing tools with ACS to actually assess the risk factors of families.

We also look very highly at families that had medical needs for infants in care and worked very closely to coordinate their medical services with our shelter staff. In terms of developing appropriate supports for families, one of the things that we did very closely at DHS was increase family visits. So family with children under the age of five get a weekly visit from a case manager which actually reviews safe sleep practices with each family. They check the cribs to ensure that the cribs do not have bedding. And if there's bedding, there's a tutorial session that is done with each family.

Last year we hired a team of social workers to actually go out and work with our provider staff and to visit each family. Over 2500 families were visited in shelters. We work very closely with our not-for-profit community, over 150 providers, on actually understanding safe sleep practices, as well as how to coordinate and work with child welfare in cases where there were preventive services.

One of the things that we're doing to ensure safe sleep practices are in place is we're looking very closely at intake. When the family comes into our intake center, there's a video that is actually played on safe sleep practices. One of the other things that we're doing very closely is each family is required to see a health educator. One of the things the health educator does is an assessment of the families' medical needs but also reinforces safe sleep. The family is offered Nurse-Family Partnership as a tool to support them. This is for any pregnant mom entering our intake center. There are safe sleep brochures, but the key thing about brochures is making sure it's in the language, the families' native language, but also for those families, as I stated before, 47 percent do not have a high school diploma, that there is a brochure with pictures that actually explain it basically.

In shelter, before any family is placed, we ensure that there's a crib for all children under the age of two. When they go to shelter, again, the video is shown and the family is given a tutorial on safe sleep practices. A tutorial is hung above the crib in terms of what safe sleep practices are for each family. There's training that we do yearly with our shelter staff on safe sleep recognizing that there's high turnover rates in shelter staff. And this year alone we did mandatory child abuse and neglect training for all shelter staff. DHS is in the process of reviewing all of our infant safety protocol and rolling out a very comprehensive training process for all of our case managers. Thank you.

**CHAIRMAN SANDERS:** Thank you very much. Before I open it up for questions, just to let the Commission know, we are going to order lunch in so we have time to ask questions and our next panel I'm sure will be quite patient, but we'll finish around 1:00 and we'll take a short break then and then we'll keep the afternoon as it is. Commissioner Covington.

**COMMISSIONER COVINGTON:** Hi. Thank you. We were remarking after hearing this morning's presentation how really cool it was to see all three logos on your presentations from all three agencies. And to us, it's in so many ways where we're going as a commission in terms of thinking about preventing child abuse fatalities and other injury deaths. It really is about

coordination across agencies. And I guess I do a lot with safe sleep because of my work with child death review. And we hear a lot from a lot of people about when do you consider an unsafe sleep death a child abuse or a neglect death. And I personally am not one to go that route because I've done the thing where you try to serve the population and do universal prevention work, which is what it seems like you're doing in a very good way, but I'm wondering if you've gotten push back, especially within ACS, with the high percentage of the kids that you're seeing are kids that are in care or under -- you know, who end up dying from an unsafe sleep practice if you're finding that tension in terms of substantiating in those cases for neglect or abuse.

**LORRAINE STEPHENS:** So I guess the best response on that is that I would say that the staff is committed to educating families, and when we are working with families known to ACS, it is built in to how we serve families. We have not necessarily filed in court on any of these families, but there has been substantiations of investigations where we clearly have seen that there have been unsafe sleep practices and there has been in fact counseling given prior to the death of a child.

**CHAIRMAN SANDERS:** Commissioner Rubin, then Commissioner Petit, then Commissioner Rodriguez.

**COMMISSIONER RUBIN:** So I'm just trying to align this with testimony we received elsewhere in the country. There's two parts to this question. One is with the crib campaign. There's been a lot of evidence presented to us that when these investigations are done, there's cribs full of stuff. And so there's been a focus on whether it's a crib versus the box, which they use in Finland, I guess you guys probably talk about it in terms of a bassinet type thing. So that's one question. The second is a relationship you clearly targeted homeless shelters, the other priority population, at least when we were down in Hillsborough County in Tampa were pregnant mothers in substance abuse treatment. Can you talk about your connection between the programs around sleep-related deaths and substance abuse treatment programs in the city?

**LORRAINE STEPHENS:** So although we do see some families who actually have situations of substance abuse as part of their child welfare history, we can't say honestly that that has been a priority in a sense of when we look at the children's deaths overall. In fact, there are a lot of families that have lost children, and these are more of our non-panel cases, which have no history where there isn't substance abuse, however we are very connected to the substance abuse community. You'll hear more about this with regard to Andrea Goetz' presentation where we actually have substance abuse programs actually on site in our borough offices. So they are actually part of our team. They are part of our training. So when child protection staff receives a person with substance abuse, we provide services to our families also.

**COMMISSIONER RUBIN:** I was asking another way, which is basically these programs that actually are providing substance abuse treatment to pregnant mothers in terms of doing direct outreach to those programs, and it's not so much about having programs with you guys that it's actually do you sleep-related work, just like the homeless shelters are doing it with the staff of residential substance abuse treatment programs?

**LORRAINE STEPHENS:** So we have not actually targeted substance abuse programs. So I just want you to understand we do have relationships with some of the providers.

**DR. BARBOT:** If I could just sort of pick up on that and address the question that you had related to cribs. I think the point for us is that irrespective of whether you're sleeping in a crib, a bassinet or a box, it's really about being alone, on your back, period. So I go back to the ABCs of safe sleep. And my experience with this is having been in Baltimore prior to being here in New York City and because of cultural norms or family resources, we chose not to focus on what they actually slept in but the message and really emphasizing the dangers of co-sleeping.

And I think to the point about that collaborating with substance abuse providers that is, in the experience that we had there, one of the subpopulations that we found hadn't really been targeted before in terms of collaborations, but when we did the forensic examinations on our cases, there were a substantial number of families that were involved in either one of those two treatment centers or systems and that was really an important next step for us as providing messages to those communities.

**LORRAINE STEPHENS:** One of the things we learned in DHS is around reinforcement. So if we found that families weren't utilizing the cribs correctly or had bedding or other things in the crib, that there was a constant reinforcement and social workers were required to visit the families more often to do that reinforcement. In terms of substance abuse coordination with the agencies, part of our assessment tool is to actually work with the family understanding what services they are involved in. And so actually reaching out to the substance abuse providers, if the family allows us to, to really understand where they're at. If we do know that the family is actively using kind of linking them to those community-based resources and getting them in a program to receive those services.

**CHAIRMAN SANDERS:** Commissioner Petit.

**COMMISSIONER PETIT:** Thank you. When you go back and look at children who have died and whether they were involved with one system or another, do you see children that were previously involved? I think you said yes, right, that children die and not only do they know the system, the system knew them, right. I guess in lead up to the question, the children that were in the system, what number are we looking at? I'm trying to figure out if you've seen families, you intervened, and then the child died after that.

**DR. McKNIGHT:** So approximately 50 percent of the deaths that we have had actually are related to unsafe sleep practices and there have in fact been history.

**COMMISSIONER PETIT:** So when there's a lack of cooperation, you go into the situation. It's reoccurred. You look at it, you advise people, and they still don't respond, you still see the problem, that must have been the case with some of the children that have died, are there ever children that are removed from families for this specific purpose?

**DR. McKNIGHT:** I cannot attest to any specific case where there actually has been a removal.

**COMMISSIONER PETIT:** I'm just trying to - - something so elevated and the parent so uncooperative and it looks like a high-risk situation, do you ever remove children for that purpose? You don't?

**DR. McKNIGHT:** No. We have not. I can't think of a case where we have actually executed a removal solely for unsafe sleep practices. There in fact would be other specific issues that would actually drive that removal.

**CHAIRMAN SANDERS:** Commissioner Martin. Or are you finished, Commissioner Petit?

**COMMISSIONER PETIT:** I have another question. Why are African Americans so overrepresented? You've spoken to that. It is triple, quadruple, six-fold, what is the reason for that? What is that associated with?

**DR. McKNIGHT:** You know, I don't know that we have definitive answers about why that might be, because the whole issue of safe sleep is fairly complex when one takes into consideration cultural norms, family norms, in addition to stressors of daily life. So I think it's difficult to have one or two specific reasons. I think -- I'm not aware of studies that have sort of compared one group to another and said, why is it that African Americans are disproportionately represented, is it because of the role of grandmothers in the African American family, is it because of the role of poverty, is it because of the role of other reasons, it's difficult to say.

**COMMISSIONER PETIT:** And the last question I have on this is, you said 50 percent of the deaths -- what percent comes from the homeless population, the 1800 you cited there were births at shelters, how many children died while involved with shelters?

**DR. BARBOT:** So I had that slide there. Less than eight children last year alone died in shelter of the 11,000 families, 23,000 children.

**CHAIRMAN SANDERS:** Commissioner Martin.

**COMMISSIONER MARTIN:** Thank you. My question goes back to the overrepresentation of the minorities that you spoke of earlier. Are there any programs that you are developing, know of that are designed specifically towards the blacks and the Hispanics to which you talked about had the highest rates of deaths and infant fatalities?

**DR. BARBOT:** So I would say we are focusing on the communities where we see the highest rates of infant mortality and sleep-related deaths and we are engaging multigenerational caregivers in being exposed to the messaging. And then in addition trying to identify credible messengers who can sort of reinforce that it's okay to have an infant sleep alone, on their back, in a crib, and so tapping into the faith based communities, tapping into other service providers, those are the ways in which -- and then having PSAs that have individuals that are representative of the communities that we're trying to target.

**COMMISSIONER MARTIN:** Thank you so very much.

**CHAIRMAN SANDERS:** Commissioner Covington and then Commissioner Rodriguez.

**COMMISSIONER COVINGTON:** Another thought that sort of came to me as I'm taking in all of these representatives and in a sense it goes back to the 21st vision that we have in terms of thinking about child protection, I mean, is it unusual for -- I think you mentioned you're creating a staff of seven to really focus on safety. But sort of prevention workers, not CPS

workers going in, is that new for you? Is that a new thing for child welfare to be involved in sort of that early end upstream prevention work?

**DR. MCKINGHT:** Actually, I would say yes, because generally, the child protection workers actually have somewhat served in this capacity and again, once the family has come to our attention, what we're trying to do is be much more present doing much more primary care and being involved in the community, being a part of the community to educate families prior to. So this is very new. We are very pleased to be funded. I think we positioned ourselves well again with regard to having the funding and working with our colleagues in order to do this, and we do think that this is a great strategy. I do have to make a clarification which was raised with me just with regard to a background point, I had indicated nine percent and 12 percent in 2010, it was .9 percent and .12 percent. So my apologies.

**CHAIRMAN SANDERS:** Commissioner Rodriguez.

**COMMISSIONER RODRIGUEZ:** You know, I was curious in thinking about some of the cultural issues involved with co-sleeping whether the campaign has taken sort of an absolute approach of baby always on the back, always alone or if there has been any attempt to do kind of harm reduction for parents who -- because there is not one set of information that's out there that parents are exposed to. There are sort of multiple messages, and it's not like using a seatbelt where sort of nobody would argue that it's good for a child to not be strapped into a car seat, but it's possible that parents hear through their own family, through the media, through pediatricians that co-sleeping is actually an acceptable practice, so is there any effort to mitigate that harm for families who continue to co-sleep despite hearing the campaign information?

**DR. BARBOT:** I think it would depend on who you spoke to whether there were absolutes or not. I think there are, certainly from a public health perspective, we would say that there is no safe sleep other than alone, on the back, in the crib. And so recognizing however that parents want to feel connected and we want to promote bonding, part of what we've incorporated into the graphics for our campaign is to show that the parents are in the picture, right. So alone doesn't mean alone in the room, it just means alone in the sleeping environment, and the bassinet or the box or whatever it is can be right next to the bed, but that in reality, there is no safer sleep environment than alone, on the back, in a crib.

**CHAIRMAN SANDERS:** Well, thank you very much to the panelists. Really outstanding. And our final panel for this morning is going to talk about New York's crisis response in the clinical consultation, the instant response. And we have Susan Morley, Deputy Chief Michael Osgood, and Andrea Goetz. We heard from Commissioner Carrión early on about the Instant Response Team and so now we got to hear more detail. Ms. Morley.

**SUSAN MORLEY:** Good morning. I'm Susan Morley. I'm Senior Advisor of Investigation to ACS and I am a hybrid. I was with the PD for 21 years back when we created the protocol that I'm going to speak on and almost 10 years at ACS, so I come, I think, with a little bit of a unique perspective of seeing the challenges from both agencies. So the creation of the Instant Response Team developed after a high-profile child fatality, Elisa Izquierdo's death, is actually when ACS became its own independent agency and the Mayor basically said ACS, who Vashna Sheeny (phonetic name), represented then and NYPD, who I represented then get in a

room and figure out how to work together on the most serious cases so we can do better work and prevent some of these fatalities. So we really appreciate the Commission's work.

So we developed it. It wasn't easy. We started with about 50 people in a room and it came down at the end to about four of us after hearing from everybody and we really knew that we had to get agreement between the real front line in the investigation, which was CPS and the detectives, primarily the special victim squad at the time. The first -- our team was called in May of 1998, and historically, it's been about 46 percent of all the cases called to the SCR that are assigned to New York City. The past year actually rose up to seven percent, over seven percent, because of a lot of the work we've been doing in retraining our Instant Response Team coordinators on the protocol, either agency which is important in triggering IRT and the mission basically is to do a coordinated child protective investigation and have law enforcement and district attorneys and CPS work together.

The goal we wanted to minimize is trauma to children. There was a study at that time by Victim Services that showed kids were being abused eight to 23 times. And just think about the kids you know and how horrible that is, not only for the kids but also for investigation. So we wanted to reduce that. We wanted to be able to gather information from the police department's perspective very important for effective time because ACS could not give us cases directly at that time until we developed this protocol. It had to come through the DA's office, and this was the height of the crack epidemic and we were getting cases sometimes very serious six months later, so we were very much for this protocol.

When I say "we," I was with the NYPD at the time. This is pre CAC. The CAC in Brooklyn, the first location in the country, was created back during this time in 1996. Again the full location came as a result of the work being done after Elisa Izquierdo's death. One of the goals we had was, let's remove the abuser from the home rather than the children. Kids fear being removed. It is a big problem for disclosure.

So we go out on fatalities together, severe abuse, we kind of train you know it when you see it. And when a child discloses sex abuse, to me it's key to get out there soon. It's key to get out there together, because we have to be ready to listen when these children are ready to talk. The research on disclosure shows that most kids do not disclose, so that when they do, we have to handle it carefully or it leads to recantations which is a big challenge in investigations. We have an IRT coordinator, kind of a quarterback. Either agency can call the IRT coordinator to institute the IRT. They do preliminary screenings a lot of times with the source because sometimes there's not information and they're trying to see, does this fit our protocol so we have to do some preliminary.

Big thing with IRT at the time was CPS traveled by trains usually and the police had cars, so the police are going to be there a lot quicker. So part of the IRT protocol is providing transportation for the workers when an IRT is called. The coordination with the Child Advocacy Centers, I'm happy to say, we have, I believe collocated child advocacy centers, I was told not to get into them too much because you've heard about them around the city, which ours are amazing, some of the people are here today. And we do a lot of the work together. So the cases are identified how the call comes in to the SCR. If it fits our protocol, we call an IRT.

CPS goes out on a case and discovers injuries of sex abuse at this IRT, they can then call an IRT. The police department, they come across something that fits the protocol, they can call an IRT. We also have a special radio code developed for CPS to get assistance when they need to do a removal or warrant, entry orders. Of course if it's an emergency, they call 911. If not, we use our IRT coordinators to get assistance when it's more preplanned.

The NYPD created, Mike, and myself have added an Instant Response Team unit after the death of Nixzmary Brown. In 2006, we re-looked at the protocol. We strengthened the protocol and we created a database where we can electronically notify each other and let each other know whose getting assigned. So citywide data, this is just a chart to compares the SCR reports, different theories. 2005, pre-Nixzmary, you see the jump after child fatalities in the SCR reports and you'll see the jump where we did a lot of the training in 2013 and 2014 with our IRT coordinators on the protocol and we see a larger percentage of IRTs being called.

One of the things ACS has that is unique, some agencies have some form of it, we have over 122 retired law enforcement who work spread out throughout the field offices and they also help with the IRT protocol in that they are enriched in law enforcement and they catch cases when the CPS comes to consult on a case, we will do screening questions to see if something fits our IRT protocol that wasn't called. And if that is so, we will either have the IRT called or at least reach out to the CACs and the DA and say, this is a case we have to work on jointly.

This program was established in 2006, again, after a child fatality, some reform work, and they all have over 20 years' experience in child abuse, domestic violence, special victims, homicide, missing persons, narcotics, warrants, juvenile crimes. They're all former detectives or detective supervisors. I even have a detective captain. The role is to basically help CPS on difficult and challenging investigations.

We help obtain information from law enforcement. We provide on-site training, work and safety training. We use databases to help us, and I can describe just something really quick where a worker went to an IC and said I have a teenager in that room now that's saying her and her family live in a hole in the ground. She don't know where it is. She's not allowed out of this hole very often, and I don't know if this kid is crazy or what's going on.

So the retired detective went in and spoke to the teenager, and he too said to me, at first I thought it was a little crazy, but something about the kid I found very credible. So using technology, Google, and his knowledge of the area, the former detective that worked the area, he said, did you ever come out of the hole, and she said when dad took us to the library occasionally. Describe the library. Describe anything you saw at the library. An overpass. So he went on a search for the library. He looked, he had a knowledge of the area. He thought he knew the area that it could be and he took the child through a virtual walk on the computer of the streets and identified the location.

They went out there -- and he's still not sure this is true -- he goes out there, it's one of these old tin metal doors from New York, those cellar doors by the stores. And they hear noise. This is where you live; this is where I live. So they call the police, because they don't know what's down there, and they get assistance. And what we find is a very large family living in a dirt

cellar urinating in buckets with a very malnourished teenager that probably was going to die, and mental health issues, just the whole family.

So that's how we link in to prevent a fatality I thought that was a good example. We help locate children and families. A lot of times cases come in with unknown names, who really lives in the apartment, the address is wrong. We use all kind of databases to help with that. We changed the law in New York to get direct access to criminal databases. We used to have to rely on the police department. And with more than 60,000 cases a year, the police department has their own work. We asked for direct access. To get that passed, we had to lose something. And what we lost to get that passed was the ability to have the open arrest information and that's a legislation that's pending, and in my opinion very critical to the work we do. We did get direct access to the domestic violence database and that would be a recommendation that if CPS does not have access to that across the country, it has helped in identifying risks.

It has helped in locating children and families at risk. So it's very important for them to get access to that. We helped identify CSEC youth, Commercially Sexually Exploited Youth. We get phone numbers. We Google them. We find them advertised on back pages more times than I would like to tell you. And we're doing a lot of work in that area. We respond on the fatalities, because you have a fatality, now there's siblings to consider. The law enforcement is doing their homicide investigation and they're prone not to want to share, and understandably so, they're doing an investigation. But we have to consider, what do we do with the siblings, are these kids at risk. We are resources for these siblings and we do have to remove them until we know.

So it's really important that communication. We have a partnership with the sheriff's office from the juveniles who go AWOL from our Close to Home Program. Last year we did almost 65,000 consultations. They can come back to us more than once and we do the criminal and DIR. That information has been so critical in informing safety. And I know that sometimes the legislature is hesitant, civil rights, civil liberty, but we need the pieces of the puzzle to be able to get to well-being.

You need good investigations. Without good investigations, you don't get to well-being. You want to refer the right services, you need to know what's going on in that household. There are also some challenges with confidentiality. There are also some challenges with what you can share with unfounded reports, because the review of fatalities show us many times those unfounded reports meant something. And in New York, we only have two choices of closing the case, either substantiated or unfounded. We don't have a middle ground. In the early '90s, they tried to make four different closings. It didn't work out. So I always feel like unfounded doesn't really mean unfounded, it means we couldn't prove anything at the time. So when other agencies hear unfounded, the message is, oh, there's nothing to that. And that, I assume, is not necessarily so.

We are also doing a lot of work with recantations, because if a child recants, and I always when I do training, don't be happy about a recant because we really need to evaluate whether that recant, is there something to it. We have a policy where our CACs that came out with recantation guidelines, and we're about to do another conference in November on this and we partnered on this, lets really closely look at these recants because when a kid recants, it

becomes very tough for the police to make a case and it becomes even tough in Family Court to make a case. And our communication in any investigation becomes really important because sometimes we can do something in Family Court that they might not be able to with the higher burden of proof to protect the child in criminal court. So I'm going to turn it over to Chief Osgood because I could go on and on.

**MICHAEL OSGOOD:** Good morning. I'm NYPD Deputy Chief Michael Osgood. I want to thank the Commission for giving me the opportunity to speak today. I've been privileged to command the NYPD Special Victim's Division. I've been an investigative commander in the NYPD Detective Bureau going on 14 years with a total of 32 years of service. For the past five years, I've led employees sworn members in 12 special victims' investigative groups. I work with five child refugee centers and I'm responsible for four fully operational child abuse floors.

In the past five years, I have managed close to 20,000 child abuse investigations. There are two key points I would like to make in regard to criminal child fatalities. One key way to assist the reduction of criminal child fatalities is to have an immediate response to all child abuse allegations along with an immediate rigorous investigation, and if the evidence exists to affect an arrest as quick as possible. This will help modify wrongful behavior and reduce the probability of acts that could lead to criminal child fatalities.

The second point I would like to make is, criminal child fatalities are very difficult investigations. They require a very skilled criminal investigator who is trained and practiced in the child abuse investigative process and who maintains disciplines for that process. The investigator must possess a strong knowledge of child physical abuse medical science. Most investigations of this type will hinge on medical science. For those of us, like Sue Morley and myself, who have done many of these investigations, it's clear they are one of the most complicated investigations to undertake.

They have many constraints to them, including one does not want to falsely accuse an innocent parent or guardian of such behavior. In saying such, I will offer the following recommendations. One, dedicate funding to enhance child physical abuse and medical sciences' current body knowledge. These cases pivot on the medical science. Two, establish a child abuse investigation process course under the management and controls of the Federal Bureau of Investigation in which local police departments can have their investigative training. There are 19,000 police departments in the country, many of them, because of their size, don't have the capacity to develop the appropriate child abuse investigative process skill set. Three, outtake funding to establish child abuse specification for medical doctors, not just for pediatricians but also uniformly for emergency room physicians who are the first to encounter the injured child. It's very important that the emergency room physician tells the responding police officers this appears to be child abuse. And four, and last, in any way this Commission can support and embrace the Child Advocacy Center, the CAC plays a key role in the child abuse investigative process. Once again, thank you for the opportunity to speak. Thank you.

**COMMISSIONER COVINGTON:** Thank you.

**ANDREA GOETZ:** Good morning.

**CHAIRMAN SANDERS:** Before you get started, we have a commissioner who has joined us on the phone and she actually has a question or two. Commissioner Ayoub.

**COMMISSIONER AYOUB:** Ms. Morley, you briefly touched on commercially sexually exploited children.

**SUSAN MORLEY:** Yes.

**COMMISSIONER AYOUB:** And I just wanted to ask you to talk a little bit more about what that connection there is. So for instance, most experts agree that that population of children need different supports than other abuse victims. So when you're responding, how are you responding? Are they being put in the same foster homes or are there specially trained support teams for that population of kids? And my other question would be, when you're identifying these kids, are they mostly being exploited by outside people or are these familiarly trafficked children?

**SUSAN MORLEY:** New York State and New York City has actually been doing a lot of work on this. New York State has its Child Rights Project and partnered with the International Organization For Adolescents and they're actually coming out with a whole blueprint on this. We also have the Federal Trafficking Legislation that was passed, 2980. We all are -- the state has been hosting and meeting all of us to develop policies. We have been doing a lot of training within ACS and across the state, and the state has actually given money to a bunch of different counties across the state. We have joint phone calls on it. So that's just a little bit of an overview.

We had residential foster care, which is unlike most places, we have our JCC residential foster care program for those that want to come out of the life that are in foster care. We have St. Luke's New Beginners Preventive Program where the goal is to try to keep the child home with the parent, and if they can work together to keep them safely in the home, we tried to do that. We work closely with GEMS, who they're a known expert in this area, Girls Education Mentoring Services. We have Safe Horizons CSEC consultants located at our children's center that we funded with our Safe Harbor funding that the state had given us. And one of the things that we have them do -- this is a population that's really AWOLs, despite everything you do. And we all have really come to the point that every contact is another chance to reach them and we need to do harm reduction and you have to let them know where they can go for help when they're out there, such as Dr. Angela Diaz's clinic and GEMS, The Door, the HMI. So we've been doing a lot of work with this.

We have put some youth employment targeted positions for kids that are at risk for CSEC to try to help them get employed. We have created a child trafficking bail bonds, a trafficking record that reports to me and for just a short time we've had the child trafficking mailbox. The CPS asked for help on these cases. We have youth -- if they're AWOL from a youth, if they're AWOL from a group home -- we had a youth recently get on an MTA bus and get recruited by a female 25 years old. So it is a challenge and we are testing a screening tool. We're going to be implementing a screening tool, and we're also waiting for some additional guidance from the federal government with the new legislation before we -- we do have a policy a best feed.

So what we do is if we identify a child that's advertised on back pages, we reach out to the NYPD's Human Trafficking Unit. And there's one case that pops up in my head that that night they got her back. It doesn't mean the child is willing to talk to them, doesn't mean the child won't be staying with us, but we are trying to do as much as we can to educate staff in identifying and screening and build the services we need and try to change the hearts and minds of not only our own agency but other agencies as well. I don't know if that answers your question.

**COMMISSIONER AYOUB:** And have you seen fatalities in that area?

**SUSAN MORLEY:** There's one kid that comes to mind that, you know, I feel probably is a trafficking case, but I'm only thinking of one. I'm sure there's others that I'm just not aware of.

**CHAIRMAN SANDERS:** Thank you. Sorry, Ms. Goetz. Go ahead.

**ANDREA GOETZ:** Hello. My name is Andrea Goetz and I'm the Assistant Commissioner for the Office of Clinical Practice Policy and Support at the Administration for Children Services here in New York City and I appreciate the opportunity to speak with you today.

I'm going to talk to you about the clinical consultation program. The New York Administration for Children's Services launched a clinical consultation program in two out of the recommendation from the Accountability Review Panel that Commissioner Carrión mentioned to increase capacity of borough office staff to comprehensively address the many cases involving clinical issues in the areas of domestic violence, mental health, substance abuse, and medical issues.

The clinical comprehensive programs offers clinical expertise, casework guidance, training, and service referral to the Division of Child Protection staff through contacted clinicians that are located in the borough offices. So they have really close access, the CPS workers have really close access to them, but the goal is improving casework and decision-making by front-line staff presenting with clinical concerns and by extension then connecting families with the services at the first point of contact.

In 2014, just under 42,000 consultations were provided across the four disciplines. About 25 percent of them domestic violence, nearly 30 percent mental health related, 34 percent conducted by medical consultants, and approximately 15 percent were substance abuse disorders that were completed by Credentialed Alcoholism and Substance Abuse experts, CASACs. As you might anticipate, many of the clients we serve have recurring disorders and for those cases, CPS workers can request a cross consultation so that the appropriate experts can be at the table and weigh in on the needs of the family.

ACS works closely with numerous local city and state agencies to ensure the best possible referral and support system for the families that come to our attention. The consultation team plays an important part in maintaining those connections in order to access services as quickly as possible. The creation of the Children's Cabinet that Deputy Richard Buery talked about has helped make these collaborations more robust in actual realtime. As I mentioned, there are four types of consultations that a child protective specialist or CPS worker could access. For families experiencing domestic violence, CPS workers first get a list of prior

domestic incident reports and criminal records from the investigative consultants, as he mentioned. CPS workers also administer domestic violence screening to assess the violence that may be occurring in the home regardless of the allegation. This is a universal screening tool. That information gives important insight to the CPS worker, as well as the domestic violence consultant, in identifying patterns of abuse, intensity, and frequency of reported abuse as well as criminal behavior directly or access to weapons, which increases the risk for the survivor.

The domestic violence consultant model best practice by using gender-neutral language that encourages differential response to identify the abusive partner and highlights coercive and controlling behaviors. Recommendations for safety planning for the entire family, including the abusive partner are also discussed. Through our child welfare domestic violence initiative of collaborative projects with several provider agencies, a 20/60 batterer responsibility program is offered with a goal of the abusive partner to take ownership and responsibility for the impact of the violence and controlling behaviors have on the children and family. In parallel, child-parent psychotherapy is offered to the survivors with young children to address past and current trauma and support the survivor and child in creating and maintaining a safe, healthy, and predictable relationship thereby decreasing the approaching of toxic stress that Dr. Briggs referred to earlier and changing the model of healthy relationships so that the young child does not grow up with violence and control being synonymous with love.

Addressing early childhood trauma is critical to preventing maladaptive coping skills and mental health issues later on in life. Medical consultants or nurse practitioners that provide medical consultation for our front-line staff who are also collocated in the borough offices. The age, medical condition, and childcare needs of a special medical needs child increase their vulnerability to harm and places additional stressors on the family. These stressors can increase the possibility of abuse or neglect. Careful assessment is necessary to determine if caretakers involved in the care of the medical and daily care needs of the child and to ensure that supports are available to assist them. The addition of the medical consultants can play an important role in preventing serious injury or fatality.

Mental health issues have been identified in at least 25 percent of the cases that come to ACS's attention. Mental health consultations are child centered, stress based, and trauma-informed. Consultants are licensed social workers with experience in child welfare and take into account the behaviors and the mental health history that impact family functioning. I feel that one of our best prevention tools that we have in the investigative phase is to look at not just what's happening with the family right now at this moment but more so of what has this family been experiencing going back to when those parents were children, so not just a picture of the family but the movie. I think that if we have this kind of insight, we know how to best then support families and set them on a positive trajectory so that they don't become a frequently encountered family.

Substance abuse assessments make up approximately 20 percent of the investigations which I'm guessing might be under record presentation. When substance use is suspected, CPS workers refer clients take CASACs. Credentialed Alcoholism and Substance Abuse counselors, that are collocated in the borough offices. This is a little bit of a different model because the CASACs meet directly with the family, with the parents, and assess the family in the office. So the calling center screens and assess the severity of drug and alcohol abuse and can

receive follow-up assessment and treatment on site. These are Satellite 822 clinics that are in the offices. The availability of the service for clients at the first point of contact and get them engaged in the services they need to cope with addictive behaviors that impact parenting skills and family safety and well-being. The purpose of the consultations is to provide a clinical lens to a particular case and to assist the CPS worker in identifying red flags or issues of concern that impact social emotional health, positive parenting, and the well-being of the family.

Armed with an understanding about how past trauma, a particular mental health diagnosis or pattern of coercive and controlling behavior can impact family functioning, CPS workers are better able to holistically assess the strengths and needs of their client. Consultants also provide referral information for all of the identified members of the family, not just the subject child and parents, but other relatives that might make up the family composition. Giving CPS staff the time they need to process the case, discuss a family in detail, and make appropriate referrals will ideally lead to reduced repeat abuse and neglect. In addition to formal consultations, the CPS staff and clinical consultation teams also participate in child safety and family conferences, offer crisis debriefing following a fatality or a particularly intense case and offer office-based training based on their areas of expertise.

CPS has said about its consultants, it's useful when they give you extra guidance on questions to ask the family that can essentially turn up. So they look at the risk issue. I used to just ask a client, are you doing okay? And now I ask directly, are you feeling like killing or hurting yourself? What is your plan? And I get the answers I need to be able to get the client the help that they need. The clinical consultation program is widely viewed as critical for boosting the quality of caseworkers on some of CPS's most complex cases while strengthening the clinical capacity of the child protective staff to decrease this occurrence of serious injury or fatality to our most vulnerable New Yorkers. Thank you.

**CHAIRMAN SANDERS:** Thank you. Commissioner Zimmerman.

**COMMISSIONER ZIMMERMAN:** I just, as I'm thinking about all of these risk factors around the potential child abuse and neglect fatalities of children -- and this is for any one of you three -- domestic violence plays such a particularly key role across the board for child fatalities or abuse and neglect. I'm wondering if as I'm hearing about all of these sort of mother-guided interventions and prevention programs what the role of being under the influence of a substance during the time of the incident where the child is either a shaken baby or an actual physical abuse case rather than a neglect case and we always say that they get a referral for substance abuse.

I know in rural America that means sometimes a waiting time of nine weeks, and then if there's funding, then you go to a facility that's three states away. So what does that look like when you say you do a substance abuse referral here and then the other part is what's the role of being under the influence during the time of the incident?

**ANDREA GOETZ:** So I can speak to the substance abuse assessment. Because the CSACs are located in the borough offices and families are assessed and trying to receive treatment in the borough office during the time of the investigation, the age is to connect them with services right away so that they can get the services at the first point of contact and then if

they need ongoing services. So individual group services can take place in the borough offices as well as other kinds of screenings and assessment, and then if ongoing services are needed. Because these are sort of satellite clinics of current provider agencies, it's much easier. They have sort of a straight pathway then into the home agency if they need more intensive services going forward.

**MICHAEL OSGOOD:** For myself in investigating many abuse cases of children, I don't believe being under the influence of alcohol or a controlled substances are that common. I don't think that's the mover. I think what the motivator is you have a person in the household who gets triggered at a point in time, more than likely from the stress of whatever is going on at that time. So you have an infant that's sick. You have a household where things ain't going well. I had a recent case of male who believed the child wasn't biologically his and then they are alone with the child and they trigger. And then the action they do winds up injuring the child and/or killing the child. So I would say, and this is only from my experience, that it's not a controlled substance, it is the stress of whatever is occurring at the time that triggered that person at that time.

**SUSAN MORLEY:** When we do the fatality review panels, you do see substance abuse quite a bit in the histories. They don't even, let's say a sleep death, like, it's speculation, was it drugs, they don't test the parent. Half the time you're not sure what you have unless it's an obvious homicide where the baby is beaten and you know somebody did something really wrong, right. Sometimes you may get fatalities that you don't find out until the medical examiner does the autopsy that something is lacerated internally and then everybody has to scramble because, like Mike said, if there's no outward signs of trauma, you don't know what happened yet and it's difficult to investigate because the parent is in so much trauma and at the same time you got to kind of lock them into statements just in case there's a homicide down the road, right.

So it's challenging. But I agree with Mike that a lot of it has to do with frustration, low tolerance levels. The DV and having access to the DIRs, the domestic violence incident reports, are key in assessing risk before you have a fatality. And I'll always in training say, what's worse, 20 domestic violence incident reports or two? And everybody will start a little debate and I'll say, well, what if the 20 are they delivered the child late to their visitation visit and the two are he choked her out once and another time he gave her a black eye. So oh, well then those two.

So it's gathering all the info and trying to fit the pieces together to determine the risk, and that's what we really have been trying to get better at in training and the work we've been doing. And that's I think what my program with the retired detectives really helps with that, right. It's not just about reading these DIRs, but you need to read these DIRs to see what's going on.

**CHAIRMAN SANDERS:** Commissioner Martin.

**COMMISSIONER MARTIN:** Thank you. Are you a detective?

**SUSAN MORLEY:** I used to have his job.

**COMMISSIONER MARTIN:** I have two questions if you don't mind. So in your program with the retired detectives, which I think is wonderful, we've heard about a similar program somewhere else, not with retired detectives but retired workers, when does the worker have the opportunity to call upon your services?

**SUSAN MORLEY:** So we encourage them to come for a consultation as early as possible because we conduct a criminal and domestic violence background check for them. So when we train, we say come to us as soon as you can. You don't want to come to us on day 55 when you're closing the investigation, because what you find out may turn your investigation all around, right. So we try to tell them come as soon as possible and what we do is we have screening questions because when we first created it, you know, if you're from the child welfare world and you're hearing you're getting retired detectives to help you on your case, but they are not catching the case, they're helping you, it wasn't a big hit at first.

We had to kind of prove ourselves what we can do. So once they realize we could do the criminal and DIR checks for them, then we had to start building screen questions instead of I don't know why I'm here, my boss sent me. So then we said, all right, let's -- they'd be coming to us with criminal DIRs but they wouldn't tell us the child was missing and we could help with that, right. So we did a lot of learning to build the program. Now we ask how old the child is seen, is there confirmed sexual abuse, confirmed physical injury, was there law enforcement, are the DAs involved, and we'll ask questions like that and then get more deeply involved depending on the answers to those questions.

**COMMISSIONER MARTIN:** So is there an opportunity or are there times when the worker will do an initial investigation, call you in shortly after that, you do some preliminary work and then the case is unfounded or the investigation is unfounded?

**SUSAN MORLEY:** I'm not sure I understand that. We do some work. They go on and do their investigation. They come to their conclusion, which is unfounded. Okay. That happens.

**COMMISSIONER MARTIN:** What happens to your report? Does your the report go into the NYPD file?

**SUSAN MORLEY:** I'm with ACS now.

**COMMISSIONER MARTIN:** You're in the agency?

**SUSAN MORLEY:** Yeah. We're all ACS employees. We are retired from PD but ACS employees and we have our database to capture our work and CPS gets a copy. And they also can review it online.

**COMMISSIONER MARTIN:** So the agency hired the retired detectives.

**SUSAN MORLEY:** Yes. Not as consultants, we are actually employees even though the functional title we use is actually protection agent is the title.

**COMMISSIONER MARTIN:** I was wondering about your authority. I was kind of getting there. Thank you. You cured that issue for me.

**CHAIRMAN SANDERS:** Commissioner Petit.

**COMMISSIONER PETIT:** We could probably get most people to agree that we don't want to criminalize any more families than we need to, and my guess, having been in the business for a long time is probably 95 percent of the households that get brought to our attention don't need law enforcement per se. CPS and everything that surrounds that might do the trick. But there is that two or three percent that gets killed each year. There's reasons to think it might be as high as 3,000 and you guys have had a number that has been constant for about the last eight or nine years, which is about 100 or so deaths a year.

So for the moment, I'll make no assumptions about people coming on and if it changed the amount and it sounds like it might have from the safe sleep babies to whatever else is going on, in terms of law enforcement being more involved in these cases, which I'm a very strong advocate of in the small percentage of cases that it's needed where guys were beating up women, killing kids, doing time, going from one jurisdiction to another. So I'm going to ask a question that I don't know if anyone knows the answer to, but what would happen since the number hasn't changed over the last seven or eight years, without regards to what that populace looks like, what would happen if you eliminated the unit, if you said we're not going to have the unit, is there an argument to be made that the number of kids killed would increase, could you prove that? And what if we said double the spending, the police say, listen, we think you guys got a great model, it needs to be further expanded, we're going to double the spending, would that reduce one death year?

I mean, right now with the work that you guys are doing, how is it translating into increased arrests of certain types of behavior in which we would agree an arrest is appropriate or the issuance of domestic violence restrained, there's four prosecutions by DAs, so for me, a critically important component of CPS as we now know it is this law enforcement piece, which you guys are doing, but the numbers don't seem to change. There's still 100 killed each year.

**SUSAN MORLEY:** Not killed, just with history.

**COMMISSIONER PETIT:** Look, you've got 100 kids a year that are killed.

**SUSAN MORLEY:** The homicide are -- homicides in New York City I'm talking about were eight to 10.

**COMMISSIONER PETIT:** Let's take just abuse and neglect, so there's 100.

**SUSAN MORLEY:** So they are much lower. I have to believe it would be higher because we are doing such better -- there's two pieces to this. There's my unit, but then there's our coordination with law enforcement that's been going on for a long time.

**COMMISSIONER PETIT:** Why doesn't the number change? Why don't we see 100, 90, 80, 50, 30?

**SUSAN MORLEY:** I wish I had the answer to that because we are doing such better investigations, we are definitely protecting kids. I gave you one example. I got tons more I could give you.

**CHAIRMAN SANDERS:** I'm going to ask you to go through it quickly. We have three more questions we need to get to. So go ahead.

**SUSAN MORLEY:** So the homicide number is small, but one homicide is too much, right, if we can prevent it, right, but I think the work we're doing and the work we're doing with the CACs and just all the knowledge we have that we didn't have to then inform safety and risk is helping kids. And even the coordination that we do together is helping kids.

**COMMISSIONER PETIT:** I'm not questioning accountability, I'm just saying for us to go forward as a commission to approach the White House and to approach Congress, we're looking for real numbers that show declines and whatever it is and that's what I'm looking for, so it sounds like...

**MICHAEL OSGOOD:** I would say that's probably the key question, and I could probably offer this, is that the New York City Police Department Special Victims Squads have been doing child abuse investigations focused and dedicated for about 40 years. So we've had focused law enforcement investigating for 40 years, so we're in a steady state. So two, in regards to criminal child homicide investigations, 2014 we have about 15. So if you look at criminal deaths relative to the population, New York City has about 10 million people at any point in the day.

In 2014, we had about 15 child criminal deaths. There were six to seven that the ME couldn't determine, so that's a very low number for the whole population. So there is a relationship to actual criminal investigation to the overall population. You have a complex problem to solve. How do you indicate such a low number in regards to general population? I could say as a police officer who has witnessed an 80 percent reduction of crime in the City of New York, I can say with great expertise that it's when the police interfaced in a system on system basis that we modify behavior and increase the order level inside the social system.

So I would have to say as a practicing police officer for 32 years that the law enforcement division, police integration of a specialized force has to work. Because I have seen it visually in direct operation. I've seen it in the last 20 years when we've driven out crime 80 percent.

**CHAIRMAN SANDERS:** Commissioner Dreyfus. Commissioner Bevan. Commissioner Rodriguez. And Commissioner Rubin. And then Commissioner Ayoub.

**COMMISSIONER DREYFUS:** Thank you. I find this fascinating what you're doing and, go New York City. We've been looking a lot around the country at this whole issue of multidisciplinary teams. We certainly know, those of us that have been doing this work a long time, there's the idea when we got really high-risk cases, really problematic cases, a lot of bad things going on then we'll put teams in place, but as a commission we're starting to ask the question, shouldn't teaming be happening sooner, earlier.

Listening to you talk, I started thinking about two things. One is, might this commission -- I don't know that I need you to answer the question, maybe think about it and get back to us -- might this commission think about a triaging of sorts, some kind of algorithm that we might find. When you talk about five to seven percent, you're doing the instant response. Is that what you called it?

**SUSAN MORLEY:** I guess that would be our triaging.

**COMMISSIONER DREYFUS:** My question is, sitting underneath that five to seven percent number, is that the right number that needs that level of teaming? Is there any algorithm that

might be sitting underneath that data that would say there's some defensibility behind saying that's the percent of cases that need that level? So your part of consultation -- let's just take 100 cases, 100 cases going out for investigation. Could we find ourselves with the experience of New York City being able to say, this percent just needs a very classic investigation, the investigator with their supervisor doing their part, that's all that's needed on this percent. This percent likely consultations are needed. I mean, my God, 42,000, that blew my mind. But then this percent of cases, no, we need a real multidisciplinary team on these cases from the very beginning, not toward the end. So I'm just wondering if your experience might start getting to some algorithms that might sit underneath. Because if we just say multidisciplinary every case, who could afford that?

**ANDREA GOETZ:** Right. I'm not the expert in this, but there are others in the room that can definitely speak to this more efficiently than I can, but we are looking into some predictive analytics, as was talked about earlier, so I think there's sort of a lot of different -- there are a lot of different risk factors and algorithms that we can put together and I think that we are looking to put together to try to help inform casework practice and differential response a little bit more clearly. And we certainly, the clinical consultation teams sort of encourage, taking as I said before, sort of a holistic look at the family.

So maybe there's a diagnosed mental health issue and they had some time in a homeless shelter and the parents have some past history with the child welfare system and the child is not going to school, you know, and oftentimes, we focus on imminent risks, but also there are all these other risk factors that are going on with the family that are impacting the family functioning, and so to be able to not just deal with the imminent risk that may be presenting to the child, but also what could we really do as a supportive measure to the family to put in place so that they don't become frequently encountered simply by the daily stresses of life and poverty and strife in New York City.

**CHAIRMAN SANDERS:** Commissioner Bevan.

**COMMISSIONER BEVAN:** I have one question, and it's, should the Instant Response Team, I see your criteria here, should that be expanded?

**SUSAN MORLEY:** I feel it should at sometimes be expanded. There is a case where the professional judgement of either agency you can call an IRT as well. We do come back sometimes if someone answers the phone on occasion on either end and we do intervene. I sometimes get a call from the CAC director, we think this should be an IRC and we'll ask you to coordinate the protocol, can you help us out. So the good thing is we all are in communication and we can do that.

**COMMISSIONER BEVAN:** My other question is, in terms of joint investigations, you said you needed some more information and you needed I guess the police can only access certain information and then ACS can only access certain information. What's the barrier in terms of accessing or --

**SUSAN MORLEY:** There are cases that the PD has that we don't have and there's state connections child welfare databases that we have that they don't have. So federally, we could use your help, the Adam Walsh Act gave us child abuse, you know, criminal background. What we have struggled with is --

**COMMISSIONER BEVAN:** For everyone in the household.

**SUSAN MORLEY:** Right. What we have struggled with is to really do child welfare work, we need to really disclose that and the federal authorities have told us we can't. So to the point where we're not supposed to be telling Family Court and we can't tell providers who we need to work with the family, so federally if you could help us with that.

**COMMISSIONER BEVAN:** Who federally? Is this the HHS you're talking about? DoJ?

**SUSAN MORLEY:** I think it was the FBI. I have to get back to you who because we did this a few years ago.

**COMMISSIONER BEVAN:** I would like to hear back. Thanks.

**SUSAN MORLEY:** And, you know, we had a little bit about that when we first got the criminal background we had Hanna Burofsky overcame that.

**CHAIRMAN SANDERS:** Commissioner Rubin.

**COMMISSIONER RUBIN:** I think this is a good segue also to the disproportionality panel coming up this afternoon. So for those of you in the audience who are presenting this afternoon, I want you to think about potentially what are the risks of data sharing and because I want to ask -- with thinking about that case we heard about this morning, that child who died here in New York, and thinking outside the ACS and CPS system, there's this accountability and responsibility of these agencies and so for you two here in terms of law enforcement, there were two things that I see in that case and many others like it, in this case you have a father who was arrested and there is a child receiving services or has received services from CPS whose safety probably needs, you know, should there be a level of accountability and cross talk between ACS and law enforcement that actually goes back the other way to ensure the safety of children when parental figures are removed and how should that be systematized?

And secondarily, when you have these shaken babies, when you have a violent felon who shows up in a home where there's a young child, how do we make sure that when there's active services going on that CPS knows that a violent felon and paramour has just moved into the house? What should be the recommendations around law enforcement's responsibility to report back to CPS?

**SUSAN MORLEY:** First of all, they would have to know we had a case, right. I think there needs to be a lot of thinking on that. They might not always know we have a case and sometimes we don't know they have a case. And that sometimes is why having access to the DIR database is very helpful because then we'll see, oh, they have been responding to this household for the adult DV and then suddenly there's a child abuse case called in and we do a DIR check and that's where we can partner with the domestic violence officers in the precinct, but I think there has to be some thinking to that move back. And even in that case, one of the arrests was out of state and that would have been the dilemma we just talked about.

So I think it's the more you can get the different agencies to look at what information they can share and make sure everybody really knows what they can share, because you'll hear from different people different interpretations of the law. We tried to solve this in the city in

2006/2007 with the medical community where the doctor, because of HIPAA, could talk to ACS but maybe they aren't talking to the PD or the doctor calls in a report and the kid is transferred to another hospital and that hospital thinks they can't talk to us because they're not the ones that called in the report. So there's still all that issue, so I think to the extent that we could make it a standard that, look at probation, and parole, and the NYPD are allowed to share and get that out there, I think that will help because you have new people come in and interpret the law this way and somebody else comes in and reinterprets the law and then you have problems.

**CHAIRMAN SANDERS:** Commissioner Ayoub.

**COMMISSIONER AYOUB:** Just a quick question. When a commercially sexually exploited child is murdered, is that treated as any other murder or does that go through the child abuse fatality process?

**SUSAN MORLEY:** If it's a child known to us, we will review the case.

**COMMISSIONER AYOUB:** Okay. So that would be in the number of, when you talk about fatalities, that would be included in that number even if it's not a family member who was trafficking them?

**SUSAN MORLEY:** If it's not a family member but the kid died in ACS on our watch, we will review that fatality, as long as the SCR call got called in.

**COMMISSIONER AYOUB:** Okay. Thank you.

**CHAIRMAN SANDERS:** Thank you very much. Really outstanding morning. Incredible information. So we're going to take a break for 15 minutes and we'll reconvene with a presentation from Dr. Mattingly.

(A brief recess was taken.)

**CHAIRMAN SANDERS:** Mr. Mattingly.

**DR. MATTINGLY:** Good afternoon. I appreciate the opportunity. I'm John Mattingly. I have spent about 45 years in juvenile justice and child welfare and the last 30 in child welfare, run a couple of large child welfare agencies and spent about 15 years at the Casey Foundation working with mostly big city child welfare agencies around the country. I also want to thank those who are still here, the great people from the New York systems, both public and private. It was great to see many of you, wonderful to hear how you've gone forward and I can't tell you how much I miss the people in this business up here in New York. You guys are real heroes. You don't get treated like that enough, but I want you to know you're certainly my heroes.

I want to discuss with you today a relatively narrow set of issues considering the breadth of the child death issues you're confronted with. What I'd like to talk about is what it feels like to be in, to work in, to manage, and to lead these large public systems. And having started there to give you some sense of why I think it's so difficult to improve outcomes, especially child deaths, which as you heard from the last panel members, especially child deaths, because of the numbers and the relationship of those numbers to the numbers that public

child welfare agency tends to experience. I also think that much can be done, much has to be done if we are going to do better, but it is really hard. In some -- I'm sorry to say, to summarize where I'm headed here -- but there is no quick fix to improving the public child welfare system in this country.

There's no silver bullet. We've tried, and I have been around for most of them silver bullets like Family Permanency in the '70s, Intensive Family Preservation in the 'eight0s, Concurrent Planning in the 'nine0s, and the latest being alternative response, all of which were right and were good directions to go in, but none of which were silver bullets when they're placed within the context of the real system we live with. I also want to say right out front that there also is no free lunch. Caseloads always matter. And to the extent that political leaders especially, and some media, think we can actually save money because intensive family preservation will mean there will be so many fewer kids in foster care, all of that stuff is not helpful to the people trying to do the work. So there is, in my opinion, no free lunch.

Let me start off talking a bit about juvenile delinquency, especially juvenile detention. Back in 1992 when I started at the Casey Foundation, I ran, started and designed and ran a program called Family to Family, which was a foster care initiative, reconstructing foster care. At the same time, my colleagues, really wonderful capable people, Bart Lubow and Kathleen Feely, at the foundation started something called JDAI, Juvenile Detention Alternatives Initiative. And from 1992 to this day, many, not all, but many of the outcomes and results being achieved in the detention system have improved dramatically.

What essentially Bart designed was a program by which local leaders pulled together and decided amongst themselves on a clear objective set of criteria by which the system hence forward police, detention, corrections, prosecutors, and judges by which the decision would be made whether to detain a child. Using those kind of objective criteria, places as diverse as Chicago and Portland at the very beginning dramatically decreased the number of kids locked up, which of course led to a big decrease in the number of kids getting sent away to juvenile justice institutions far upstate.

Those numbers have continued to come down across the country. If you recall, in 1992, there wasn't much interest in doing anything positive for juvenile delinquents in this country. Nothing. Nowadays, things have turned around, not just because of JDAI, but they sure got it started when nobody thought they could pull it off. What I'm here to tell you is that that's not going to happen in child welfare, not going to happen in my judgement. There is no particular set of standards, criteria, logarithms by which decisions in child welfare can be brought down to what is objective and how can we be both fair and safe for the community. I've worked all these 40 years, we've been through -- another silver bullet, if you remember, is Risk Assessment Process. Again, very good and very helpful, but not necessarily leading to big changes in child welfare.

Now, why do I say that? I'll talk more as we go along about that. But I just want to first start with two stories. First story, Queens, Friday night, 10:00, a report came in right at the turn of staff, turnover of staff, that a young family in Queens, their little children, as I recall six and nine years old, were regularly begging food in the hallway of their apartment because their parents were selling drugs and not paying any attention to them. That was the call. We go out, two people at night and on weekends here in New York thankfully, one of whom was

bilingual, thankfully. And, you know, you got to work hard to get staff who are available. Last time I looked, we have 119 languages here that had to be translated for the ACS staff. So we knock on the door. There are two little children there. There are their grandparents who we found out subsequently were brand new in the country, didn't even speak English, from a small community in Mexico. The grandparent's then hearing that they were dealing with the public officials or the police or whatever it felt like to them, grabbed the two little children and ran out of the apartment. Our two workers, one of them trailed the kids just to see where they were going, and they went to another apartment. The first worker then spent a good 40 minutes talking with the mother trying to calm everything down and see what was really going on in these circumstances.

If you think about it, given the nature of the report and the children being snatched and run away with, this was a highly dangerous situation for that family. You could see how the workers would make very quick decisions, call the police, first of all, to make sure we can maintain control. A couple of squad cars are going to come. And then you just don't know what's going to happen in a big city like New York City. Taking what amounted to two hours, we were able to determine primarily first from the young mother, who was like 21, that she had a sister who was actually very angry at them for not sharing any of their income with her for her drug habit. As it turned out, after a complete investigation, that's what happened is we had an angry relative.

We got the children back into the apartment. We talked to them separately, which you must do. We saw the shape of the apartment and the fact there was food there. The father was going to come home on the seven train at 3:00 in the morning having worked down here in Manhattan in the restaurant industry. Those of you who know the seven at three a.m., it is filled with employees from Manhattan. Anyway, I tell you that story because it is not a particularly tough case. It's not a particularly hard decision to make. It's not immediately a life or death matter, but that's the kind of decision our folks make every day, three and four times a day, and some of them with high caseload areas, 10 times a day and they have to make a quick decision and they have to know what risks they can take and cannot.

The second story is from Monday night. The Casey Foundation that I've retired from has pulled together a group of cities to help us develop better ways to make decisions in child welfare. And to do that we brought in a real international expert named Gary Klein. Gary Klein has written about decision-making a great deal. He's worked with defense departments, airlines, fire departments, CIA. So he knows what is involved in good decision-making, and we thought we would bring that to the table to help these sites learn about it.

And one of the things we have been doing with him is developing what he calls shadow box, which is a series of child welfare, child protection investigative scenarios. And with each scenario, there will be five to seven decision points where everybody stops and the new workers or the supervisees say what they would do in that situation and that then is compared to a larger group that we run before of real experts who know how to make judgements in child welfare cases and that is brought into the room without getting all of those senior workers in there every time we are going to train.

Anyway, he had begun taking those cases home and discussing them with his psychologist wife. He's got to be in his 60s I would say. His wife told him over the weekend, don't bring

home any more of those scenarios. I can't stand it. So think about the complexity and difficulty of these decisions, the traumatic nature of the daily life of a frontline child welfare caseworker and you get to see a little bit of why I think there is no quick fix, no free lunch, and no silver bullet. What can be done? A lot. A lot has to be done. None of it is simple or easy and that's the message I'm trying to bring today.

First of all, think about the kind of person you would choose to make that Queens Friday night decision who may well with the next case be dealing with a child death. Who would you want with what sort of skills and knowledge and competencies generally to make these decisions day in and day out. And then think for a minute about our processing of hiring, screening, training, on-boarding and then monitoring and holding accountable the people in our system today.

What happens, a lengthy piece is put in the paper by the administrative department describing a job that is very hard to understand what the heck it really is and that's our job description we work from and if you want to apply, you apply. Tell us your background and after three months we'll give you a test. This test is not approved by the agency affected. In my case, I wasn't allowed to see it because after all, we are dealing with Tammany Hall back in the 1920s, and that's how we built our current system of hiring to avoid family hiring the nieces and nephews of their wart healers, but here we are, in 2015 and we give them that test and then they score the test.

Maybe three months later they issue a list, perhaps 2,000 people on the list who were gathered in by this crazy piece in the paper which doesn't really describe our jobs. You must then go down that list by the rule of three, you've got to pick one of the first three and put the other two back in the mix. You go down the list until you fill your positions. It has then been nine months, a year since your position became open because the office of management and budget will only allow you to begin the hiring process when a caseworker leaves her caseload. So you've taken a year in which that worker's caseload, perhaps 20, perhaps 30 has been covered by her supervisor or by her fellows in the unit, driving the real caseloads, which is the number you really need to know, the real caseloads up through the ceiling.

**CHAIRMAN SANDERS:** Dr. Mattingly, I'm going to have to ask you to start winding down.

**DR. MATTINGLY:** Oh, I've got a ways to go. Okay. So that's the process by which we hire. I won't get into the whole process by which we hold people accountable, but what you do need to understand is the average supervisor would quit her job before she really took discipline against one of her people because of the terrible things that happen. Your own attorneys tell you, you don't have enough. This person is sitting with you for the next six months while we go through the disciplinary process and you're going to end up probably losing. So you get a sense of what I'm talking about. We must do what needs to be done, and it is a lot, to overhaul our workforce.

To build, not necessarily overhaul, we've got a lot of good people who got through this process God knows how, but we have to overhaul it. There are a lot of interests standing up fighting that. That's why it hasn't happened. That's why it's really hard to have it happen. We did a lot of it here in New York because we had Mayor Bloomberg at the time and he was

open to working it. So building the workforce is a huge undertaking but it's something we must get involved in.

Secondly, we have to develop systems by which ordinary people, like us, make decisions that affect deeply the lives of families, especially the removal and the returning decision. We need to have families in the room with us when we make that decision. We need to have parent advocates with us. We need to have their relatives with them. And we need to have a really experienced decision-maker who has been on the front line for years, who will facilitate that process. We call it here child safety conferences. I'll leave it with that. Much needs to be said about that.

Finally, we have to know what's going on in our systems. Seems pretty straightforward, but I need to tell you that in my experience, over now 30 years, generally, leaders do not know what the real culture is on the front lines of their organization. They have very little idea because that culture -- culture meaning this is how we do the job here -- no matter what the commissioner says, no matter what's in training, this is the way we do the job here. If we don't know that experientially and if we don't know the results we are achieving, those two things together, what results are we achieving, what's the rate at which this unit of workers who are closing cases, what's the rate at which those cases are coming back in the front door in six months. We need to know that.

And what differences are there between this field office, this unit of workers and this borough and what that rate looks like. We need to know that in order to be able to run and lead these organizations. The second piece of that is, people working here need to know what it is that we really expect, what it is that we think good practice is. They're guessing, because they have very little contact with us. So the question is, how are we going to do that and what can we learn from them from the barriers and obstacles that are keeping them from doing what we want them to do.

So we started something called ChildStat, which I won't get into here now, but it led to a weekly meeting at which we discussed data field office by field office and which we always reviewed in depth two cases so we could get a feel what was going on the front line. And they could hear from us, we ended up broadcasting it through all the field offices, they could hear from us what it is that we expect and they were surprised that we, first of all, could talk about cases, and secondly, what it was that that we expected them to do. I have many details I could tell you about that, but let me just finish by saying we discovered that workers thought in a case like this substance abuse case, workers thought that it was a violation of a family's privacy to do anything other than knock on the door, listen to the person who is then going to say we are not selling drugs out of here, we're doing fine. Goodbye. They walk away and maybe come back next week or the week after that depending. Couldn't talk to the super to find out what was going on in the building, couldn't talk to neighbors. They just simply got the -- quite typical of many child welfare cultures, you go in, you get the denial, you write it up on time and you close the case.

That's what we do in too many situations in this country and you can't find that out unless you actually dig and get to live with the people who are trying to survive emotionally doing this very difficult work. So there's much more that needs to be said about this but I just wanted to get on the record from the perspective of the field that we can only really make an impact on

results when we go to the basic problems and begin to try to solve them. They won't go easily. We're talking about a seven- to 10-year process at best. That's why those directors who sit in the job for two years and then leave don't impress me, and then write a book about informing child welfare, some of them. It takes time, trouble, and hard work before we can really turn around results. And certainly child death results require, as you heard some this morning what's been going on here require the hardest work over time. Thank you.

**CHAIRMAN SANDERS:** Thank you. Maybe just one question. Commissioner Covington.

**COMMISSIONER COVINGTON:** My question is, you know, you started off talking about the juvenile justice system and said it'll never work in child welfare. What is so different and why won't it?

**DR. MATTINGLY:** Because we haven't been able to, and I don't think we can develop a set of protocols and simple objective criteria which will really guide the work of those two caseworkers in Queens at night. It's a much more mobile system in which there's so much going on that you must pick up and if you're not particularly interested in other people or interested in looking into things generally, which is not really part of the competencies we're looking for when we hire, you'll just close the book on it and walk away. That's why all these good ideas down since the '70s have not really had much in the way of impact, because we haven't looked at the heart of who's making these decisions, how are we bringing them on, what competencies they need to have in order to do this, and how in God's name can we hold on to them at least for five years so they can learn the job.

**CHAIRMAN SANDERS:** Thank you so much, Dr. Mattingly. Thanks for taking the time. The next panel prepared to present we have our disproportionality subcommittee and I will turn it over to Commissioner Martin.

**COMMISSIONER MARTIN:** Ladies and gentlemen, I would ask that the panelists start coming forward if you don't mind please and while they're doing that I would like to take the opportunity to introduce all the commissioners who served on the subcommittee, starting with Commissioner Marilyn Zimmerman, Commissioner Teri Covington, Commissioner Jennifer Rodriguez, and in addition, I would like to thank Cheryl [Blanchette] who has served as our staff person who has been instrumental in helping us stay on task and getting things done. There was tremendous work for each and every person of the people I just identified.

For your afternoon, we have Dr. Rita Cameron Wedding, Dr. Paul Elam, Dr. Renee Canady. Mr. Chet Hewitt called last night and has a family emergency and is unable to attend.

Oh, Chet is on the phone. Chet, thank you so very much for taking the time to be with us over the phone even though you're having a family emergency. We really appreciate it.

Why don't we start with Dr. Cameron Wedding and then we'll just go straight down the line.

Chet, we're going to have you come in after Paul Elam and then we'll follow up with Dr. Canady and then we'll go from there.

**DR. WEDDING:** Good afternoon, Commissioners. It's certainly an honor and pleasure to have the opportunity to share my incites about the issue of violence on the impact of a child death, the issues leading up to child deaths. I want to make sure that I focus my clients on

the process of interactions of families with systems prior to the child death because I think that if we could have interventions, obviously before they get to a state of crisis, then we have a better chance of avoiding fatal outcomes. I also think that having this conversation will allow us the opportunity to strengthen the systems.

I also want to make sure that it's clear that my comments are not at all intended to question the great work that's already being done in child welfare and other systems because people are doing fantastic jobs. I just did a presentation in Illinois yesterday and I was working with Illinois judges, and one of the things that we are really clear about and was stated yesterday is that people get involved in this work, whether it's child welfare or other youth programs, juvenile justice or education, because they want to do good by people. And I want to make it really clear that I'm not at all suggesting that people are not doing a great job. I am suggesting that a better understanding of our implicit biases can allow us to possibly do an even better job.

Implicit bias, as I'm sure many of you know, there's a research that came out of Harvard University over a decade ago. According to the research from Harvard and other institutions, what we know is every individual decision-maker has biases. We all have biases. And what we're not clear about as individuals and agencies and the culture of agencies is how those biases might inform our decision-making. And so I want to offer you a few things today to allow you to think about that. First of all, I want to say that when we think about bias, it's important that we don't think in terms of both race and unconscionable acts of discrimination, the big things that used to mark biases, like lynching. While those things may occur in some places, obviously if we saw that happening in an agency, we'd do something about it. It's not that. It's more like business as usual behavior. It's an attitude, a perception. It's those things that are in my head that cause me to make assumptions and judgements about people just at a glance. It's split second decision-making.

So those are the things, as numerous as they are, that we've got to be able to capture so that we can figure out how we can make families more comfortable engaging with systems, because it's my contention, my belief, that the less comfortable families are engaging with systems, whether we're talking about education, child welfare, criminal justice, medical, mental health systems, the less comfortable families are, the less they're going to present themselves and present their problems until it's too late. So I think that that's a really critical issue for us to consider.

First of all, I want to talk about some unconscious beliefs that many people hold. As you know, I am on a faculty for the National Counsel of Juvenile Court Judges, and Dr. Mattingly reminded me that I was also a consultant in the Family to Family Program, and my focus there also was implicit bias. So one of the things that we may not be aware of, because we may not think this way, but still as I do this work across the country, I'm reminded all the time that people have unconscious beliefs that are imbedded in their ideas, for example that black families are not good families, that they are inherently just not good families.

Some of it has to do with the family structure, single parents, people who get their income from welfare, public housing, all of those things collaborate together to cause the decision-makers who are on the front line, whether we are talking about fire departments who are, you know, responding to a call or other first responders or child welfare workers, it causes

them to -- it can really trigger something in their thinking about whether or not we should be looking at something that's of a criminal nature or something that's related to the families who are in distress and need support.

I have heard over the years many social workers and probation officers, because I also work with law enforcement, who say things that suggest that black families have poor parenting skills. My point is this, if you go into the decision-making process with the belief and presumption that this group of people, they have poor parenting skills, I promise you that is going to show up in your decision-making. And it's going to make it hard for you to see family strengths that way. The other thing too is that bias is often indirectly linked to race, but it still has a racial outcome.

So for example, neighborhood bias. I was in Illinois. I'm from Illinois. I was in Illinois a couple of years ago presenting as a professor, as someone who's earned a doctorate degree, and I was presenting to a room full of judges, and one of the judges I was talking to them about my neighborhood and where I'm from and what one of the judges said to me was, I never would have thought that someone like you could be from a place like that. So my point is this, I'm not suggesting at all that this judge is not a good guy. I'm sure he's a good guy, but that's not the point. The point is, as is reported in the new book called *Blind Spot* by the researchers in Harvard, even good guys can have biases whether we're judges, whether we're professors, whether we're fire departments, it doesn't matter, we can still have biases. And I promise you that judge, if he has somebody before him who is from a "place like that," that can inform and skew his perspective of the case.

I also want to talk about attitude. I want to just talk briefly about attitude of the families and attitude of decision-makers. So oftentimes, the social workers for example in child welfare will judge a family by the perception of how they think the attitude of the mother or the parents is. So Dorothy Roberts in her work she talks about the fact that the perceived attitude of the parent are treated as evidence of risk to the child.

There's also more literature that I would like to share with regard to how the social work practices can actually elicit a negative response. The behavior of the social worker in the process of interviewing a client can create such distress in a client that it causes the client not to perform well in the interview. So there's lots of research on that as well. I'm going to try to get through my points very quickly to make sure I stay within my time frame. So a couple of other things, we have to pay attention to cross-systems bias because each entity, whether we're talking about education or child welfare, everybody is sharing reports, so if there is bias that shows up in language in one system, it's going to be transferred to another system. Every decision point then for the life of that child is going to be impacted by that bias. And judges have said to me that they can look at a report and they can almost identify the race of the individual by the language that is used to describe the people.

So for example, in situations in which the mother has just lost her child, what judges have said is that when it's a white mother, she's often described as being upset. When it's a black mother, she's often described as being angry. So those two words alone, when they are transported from one decision point to another, they cause people to have this predisposition about what's going on, and that might inform how the parents are treated. The other example similar to that is drug involvement. For white mothers, we often use the references to no

drug involvement. When its black mothers, the reference is often, mother denies or alleges no drug abuse. So language is so powerful. And other words that show up in reports like non-compliant, which are very suggestive, and nobody from one decision point really knows what that means so it gets interpreted.

The last thing that I have time for -- I do want to borrow from best practices in other systems. When I get to my recommendations, I want to be able to say that we can learn from other systems. For example, in juvenile justice, there's a fair rate of kids who are suspended or expelled due to practices related to willful defiance offenses. What many states are doing across the country is they are making -- they are changing the practice that will disallow schools and their ability to suspend kids on the basis of willful defiance because it's too suggestive, and you're just going to capture all of these kids and the one that was pushing them directly and let the schools supervise one.

And finally I'll say -- well, second to finally, I want to say the differential standard for neglect and abuse of black and white families can actually push families, black families, further outside the safety net. And that's not what we want. One of the things that does that is a differential response of child welfare. We have oftentimes identical risk factors for black families and white families but when the risk factors are identical, white families are more likely to get family and home support and black families are more likely to have their children removed. And families know that. So they're not going to stick around. They're not going to tell us things. They're not going to give us information, critical information, that we need to have in order to save their children, to help them save their children.

So finally -- oh, and I'm sure you all know the disparities with regard to abusive head trauma. And I think that, you know, one of the things I said to one of the judges yesterday in one of my comments, I think we need to look at abusive head trauma and why it is according to much of the research that abusive head trauma cases are misdiagnosed for white kids. I think that that suggests that we really need to go back in and look at that data and it is possible that implicit bias could be contributing to that misdiagnosis of abusive head trauma with regard to white kids and that might give us information that will allow us to move forward.

So in conclusion, my recommendations are as follows: I recommend that we conduct research on how the inclusive biases of individuals, as well as biases imbedded in agency policies and practices can improve service delivery. I think secondly, that we should identify these areas and outcomes that appear more punitive such as foster care placement. Thirdly, this is all -- I think you have my handout -- thirdly, I think we should discuss whether a mandatory standardized risk assessment instrument should be utilized rather than relying on the deliberations of subjective systems and agents which we all are. And then finally, I think we should identify new methodology that should include the implicit bias technology to improve the accuracy of the data production. I thank you so very much for your time.

**COMMISSIONER MARTIN:** Thank you. Dr. Elam.

**DR. ELAM:** Good afternoon. My name is Paul Elam and I am the president of Public Policy Associates. We are a public policy research, development, and valuation firm located in Lansing, Michigan and I would like to thank the commissioners as well for the opportunity to share the work that we've been doing in Michigan. A bit about Public Policy. We've been

working with the Department of Health and Human Services since 2007 to examine racial equity and child welfare policy and practices.

Part of this work involves qualitative and in-depth analysis of organizational policies, practices, and ways of thinking and acting that influence decision-making about children and families, specifically minority families. Much of the focus has been on the experiences of our families encountering the front end of our system, including referrals, intake, initial case planning and service decisions and other work has been focused on the disproportionate representation of minority children and youth and child welfare and juvenile justice.

During this time, our firm has worked with the department to engage in training, systems change, and programing initiatives to reduce the overrepresentation of children of color in the child welfare system. I'm a native of Detroit, Michigan and my public policies, research, and evaluation is typically conducted in urban communities and focuses on child welfare, trauma, juvenile crime, delinquency, to criminality, adult corrections and issues of equity and social justice. And so I heard earlier really what can we do to address some of these issues. And I think first and foremost, we need to look and see who is around the table and make sure we have folks represented from urban communities where we continue to be stymied concerning these issues.

At many national conferences that I attend and go to, I see one person that looks like myself at the table when we're talking about these issues. And so I think, I would encourage you as a first step to look and see who's sort of around the table when you have your conversations. What I want to do today is actually talk about what we can do about these issues that have been raised for some time. So what I'm going to provide is a retrospective of what the Michigan experiences actually look like.

Basically, what we have done since 2007 is, first of all, focus qualitatively in two urban communities to identify the existence of disproportionate minority contact. We did that partnering with the Center for the Study of Social Policy in 2007, Casey Families, and the Department of Health and Human Services and really found that we had disproportionate outcomes of treatment concerning minority youth and families in our system. When we had those initial findings, we didn't want to assume that that was prevalent in all of our jurisdictions within our state. And so we took it upon ourselves to do some additional analysis.

That report was released and identified the disparate and disproportionate findings. And I would have to say as a partner in the process, our department was not really an ally in sharing these findings. People didn't feel comfortable talking about these issues. And what surprised us most was that these were minority caseworkers treating minority youth and families as if it was a black or white phenomena, but it was really a black on black phenomena. So when we talk about the issue of institutional racism, somehow we have created institutions, regardless of the race of the supervisors, managers, and caseworkers, they begin to act out these particular actions. And so we document that.

The next thing we did was we created a child welfare improvement task force to look at how we can improve our particular actions within the system. So that was chaired by Pat Babcock, who was the prior DHS director, and Carol Goss, who is currently the president of the Skillman

Foundation. One of the recommendations that came out of that report is that we, as a state, need to make racial equity a priority. Most of the stakeholders believed that there was not a priority concern within our state as we did this work. We couldn't get leaders to come to the table to have a conversation systematically and to acknowledge that we actually had a problem.

Based on that recommendation, we created the Mission Race Equity Coalition where we all agreed that race, gender, and cultural equity must become a priority for our child welfare system. And that coalition was actually chaired by a Supreme Court Justice, Justice Mary Beth Kelly and a prior state representative who basically led the charge. And that coalition was actually charged by the Department of Human Services Director of Supreme Court Maura Corrigan, Justice Corrigan, who actually became the director of the Department of Health and Human Services.

The charge was multifaceted but I highlighted two pieces here. One was to identify the key decision points in our child welfare system that contribute to disproportionality. We had not done any quantitative work statewide and so that was the first charge to establish that. And then fourth, to develop and implement plans to address racial disproportionality that include measurable objectives for policy or practice change.

That work took a couple years to complete but the coalition actually issued its report. So what we did is we basically developed a state leadership team as well as a local leadership team, commission a committee on juvenile justice who was appointed by the governor of the committee and chaired by Mary Beth Kelly assumed that responsibility to make sure that we had a champion and an ally who would make sure that policies and recommendations were actually implemented based on recommendations of the coalition, who also chaired the Race Equity Coalition, the mission of Department of Health and Human Service then directed by Mora Corrigan was responsible for making sure funding was provided and jurisdictions were targeted to do the work.

And then lastly, we developed a demonstration site in Saginaw County understanding that if we were going to do this work effectively in local jurisdictions, we needed to understand the issues that stymied urban leaders within our state. We borrowed from the OJJEP DMC reduction model and looked at the same process in our child welfare system. Our state level team focused on leadership accountability and policy changes and our local level demonstration side focused on implementation tasks, learning from that process, and identifying the underlying causes of disproportionality. What we found, according to the literature and in practice, was we began to see differential treatment based on behavior.

Sometimes we found kids and families were just doing things differently and that our system responded differently. But we also found that there was differential processing or decision-making based on the same types of behaviors. And we began to drill down into that in our assessment process and ask what's contributing to this, we did surveys, we did focus groups, we did key informant interviews with approximately 1,000 practitioners, youth, and families in Saginaw County and reported those findings out to our coalition.

The first part of that work was to identify what the decision points were. We didn't have a set of quantitative data to look at, and so the coalition developed these five decision points, one

of them being how kids actually exit from the foster care system, and we really focused on child deaths in the system. To document that work, we actually laid out a data book that our state and local jurisdictional leaders can actually use. And so that process can be replicated throughout our state.

We produced a guidebook that documented how you go about establishing a leadership team, which can be replicated, and then we also found four key findings in this work: That minorities were more likely to be investigated for abuse and neglect; minorities were more likely to be removed from their homes; they were more likely after being removed from their homes to age out of the system; and then finally, if they were removed from their home, they were more likely to die in the system.

These are some of the quantitative data that we found, and as I make those points, minorities specifically were 1.2 times more likely African Americans, 1.6 times more likely to actually be investigated. Once investigated and if there was a preponderance of findings, minorities were 1.3 times more likely to be removed from their homes and 1.2 times more likely for African Americans, even though petitions pretty much push for all kids to be removed, we still had differential decision-making for minority families. Out-of-home placement, those kids who actually aged out, two times more likely to age out if you're African American or if you are a minority in general.

And then kids dying in the system. Back in 2010, you were 2.3 times more likely to die in the system after being removed. The numbers had reduced significantly in 2012, therefore, we weren't able to do a quantitative analysis there. And so what we've done is develop recommendations to disseminate these findings to make sure that our public is aware of it to continue to engage practitioners and call for competency training. Practitioners have worked for an average of 23 years and never had conversations about multicultural issues, didn't feel comfortable about it, so we had to change the culture.

Training for law enforcement officers who engaged families and many times removing kids from home contributing to traumatic experiences and then making sure our practitioners were comfortable working in high-need, high-risk communities, where often there's high rates of poverty, delinquency, and child abuse and neglect. We developed training programs in the systems, changed recommendations that the demonstration side is currently working on, and we're seeing progress.

Some of our funding partners, just to identify them, was Substance Abuse and Mental Health Services. We have received funding from System of Care grants. The mission Department of Health and Human Services receives funding from Casey Family Programs to document this work. And we're also working with the Office of Juvenile Justice and Delinquency Prevention to actually document the work and distribute them nationally. We're seeing promising approaches from this work. People are collaborating more often. We're making better decisions using data. Youth and families are being more engaged in the process and we're actually uncovering the underlying causes. We do have some challenges that remain relating to data collection, data lagging and things of that nature, but we continue to do the work and hopefully this is a model that you can consider as you think about recommendations.

**COMMISSIONER MARTIN:** Thank you so much. Chet, are you on the phone still with us?

**CHET HEWITT:** Yes, I am.

**COMMISSIONER MARTIN:** So Chet, will you take a few moments and kind of explain from your position how and what this problem really is and how it so affects our children and families.

**CHET HEWITT:** Yes. Let me just start by saying good afternoon, everyone. I want to thank the commissioners for making an opportunity to participate although I could not make the travel to New York to be with you as you work on the tragic issue of eliminating child abuse neglect fatalities. To introduce myself, I'm Chet Hewitt. I'm president and CEO of Sierra Health Foundation, which is based in Sacramento, California. The foundation is focused on improving health and well-being by addressing circumstances and places in which we are educated, work, play, and live, commonly referred to as the four components of health. We focus in our system on health equity and reduction of health disparity. This conversation about disparities in child death are important and central to our particular work. And we are involved in a number of efforts to improve the health status rapport, one of which is explicitly focused on the reduction of disproportionality of African American child death in Sacramento County. I will focus my remarks on that particular effort today.

By way of background, I am also a former child welfare worker and director of an integrated social service agency in Alameda, California, which is I guess most famous for the City of Oakland, which I served for almost a decade. Let me begin by saying in Sacramento, our journey to really address disproportion rates of child fatalities began in 2011 when a Sacramento County child death review team reported that African American children in the county were dying at twice the rate of other children.

The report which looked at 20 years of data also noted that while overall child death rates in the county had decreased, including for African American children, the African American child disproportionality rate had remained constant. It was presented that African American children comprised about 11 percent of Sacramento County's child population. So in 20 years that accounted for an average of 24 percent of all these child fatalities. The data provided evidence that interventions that worked for other children and families in Sacramento County were having a less robust than anticipated effect in African American kids.

While we knew that the whole organization had a long appeal to it, a long history, we had thought that we would have seen some decrease in that level of disproportionality, which had remained unaffected. This report showed to call action for county leadership. I will call out particularly a newly appointed supervisor, Phil Serna, who after receiving this child death review team report convened with a Blue Ribbon Commission to address the particular issues as well.

The Commission which he chaired on and I was serving on was charged by the Sacramento County Board with taking a deeper look at the issue and offering recommendation for reducing African American child death rates by about 10 to 20 percent by the year 2020. So a targeted reduction and a time. And the Commission completed its initial work in the spring of 2013, and in the fall of 2013, the county board supervisors chartered a Steering Committee on the reduction of African American child deaths to develop a plan for putting the Commission's recommendations into action. And that's a roundup of context for where we are.

The Steering Committee on which I serve as a chair is comprised of individuals from a diverse cross reference community, civic, and residence groups, safe community, parent groups, non-profit, social justice, health providers, public agencies, education, and philanthropic institutions as well. And to my previous comments, you know, we're making sure that folks who are affected are part of this conversation, their views and perspectives are represented in the strategies that we're actually putting forward.

The Commission and the recommendation controlled the board and commission report, which I provided to you. The Steering Committee presented its strategic plan to the board in May of 2015, a few months ago, at its annual budget hearing and called for a positive funding decision in June is now working to produce a detailed implementation plan. Both the Commission and Steering Committee helped identify patterns that confirmed our assumptions that the disproportionate rate of which African American child fatalities occur is more than a child welfare or public safety problem.

For example, it shows the four causes of death with the greatest disproportionality with African American children, a third-party homicide where African Americans represent 32 percent of all child fatalities, child abuse and neglect qualifies, they are 30 percent of all child fatalities, infant sleep-related deaths, where they are 32 percent of all child fatalities, and there are conditions where they are 25 percent of all child fatalities.

In addition, the data shows that 80 percent of all African American child fatalities in these categories occurred in just six Sacramento County neighborhoods. The child death review team was then compared to the data from the Healthy Sacramento Coalition Health Needs' assessments and our 2012 County Health Profile. We found that these six neighborhoods share many of the same risk factors. Compared to Sacramento County as a whole, the six neighborhoods have higher rates for risk for violence, almost twice as high, and at least twice as many of its residents without high school diplomas.

The child fatalities in these communities have a higher number of risk factors, including but not limited to childhood trauma, poverty, poor school performance and attendance. And shockingly, in some of these communities, the level of disparity by percent is considerably higher than what should be expected for the way that these states tend to aggregate on a county-wide average. For example, in the Meadowview/Valley High neighborhoods, African American children make up 16 percent of the child population, but account for 41 percent of child death in those four represented categories. Arden Arcade, African American children are eight percent of the child population but account for 35 percent of all child fatalities in this category. In Oak Park, African American children are nine percent of the child population and account for 27 percent of the child fatalities. So we're going to add to the two times likelihood of death for African Americans in some of these communities, it is actually three or four times.

In the strategic plan that was produced by the Steering Committee, we've identified prior year outcomes and core activities as a way for pursuing a pretty aggressive target over a five-year period. So substantially, we focused our planning efforts on the creation of a conceptual framework that we recognize the centrality of the impact safe, supportive, and nurturing families in communities have on child safety. That takes important steps to leverage untapped community aspects and begins to reframe the way child and family service

institutions connect with each other and the family and communities that we serve. I think the stories told by former commissioner of New York City John Mattingly and others and my colleagues really captured that in a more precise way.

The framework that we're using is explicit about the following fundamental principles, and that is that place management, child's health, policy screening is necessary for system transformation, what you measure and what you report matters. Collaboration across family service systems is essential and community family and youth engagement and development should be at the center of our work. We believe the framework that we're producing will be provided to you as well is sufficiently universal and that it will benefit all children regardless of race or class in this county over the long-term, yet it will begin its implementation by being specifically targeted for the commissioner to upgrade poor health outcomes and disproportionate death rates for African American children.

In June, nearly 300 community residents and advocates from throughout Sacramento joined our Get On The Bus campaign, which is part of an education effort, not just kind of a contestation to ensure that resources are targeted towards this particular effort, because we believe that community engagement is at the center of this and that communities that experience disproportionality have got to own and be a central part of its resolution. So the effort was by the foundation and led by our local Black Lives Matter Coalition. It terminated at the Sacramento County Board of Supervisors offices. And on budget day, the day of the vote, there was folks packed in that particular hearing room. The county approved a \$1.5 million five-year effort, 7.5 over five years.

As adult community capacity that put this strategic plan into action and this is in addition to commitments made by counties First Five Commission, which in California focuses on kids from zero to five, and every county actually has one, as well as the Child Welfare Department, which is now implementing a title IV-E waiver in partnership with the probation department as well, because the issues around that, particularly for older kids, are often about violence in the streets and while many of these kids do have prior child welfare history, that is not accurate or determined representative for older kids in families that we engaged with as well.

So we're also working with the Sacramento County's chief executive office to establish itineraries in children's policy counsel, which will bring together public agency leaders to learn things, act, and plan ways to promote child and family well-being, which is our target, child family well-being, and safety is a big part of that. We're not suggesting that it isn't, but we think that there's got to be a broader agenda, much more in line with our kind of population public health agenda, which drives the foundation's work, which includes changes in department strategy, the departmental culture, and has an impact on community relations.

So maybe communities, they see the child welfare systems as folks who are coming to get me and not folks who can help me and my family. And I think that we have really got to change that particular dynamic. And this not to call into question the commitment of many of the folks who work in this system. As I said, I have known many of these folks. They are fully committed, but perception has a huge impact on how people are willing to engage or not with child welfare systems and it's something that's really got to be re-tracked. I'll reflect on a project that we may get in Sacramento.

Three factors show up as being really critically important. First is using the data that we actually have. And while it is imperfect, and we admit that, we feel very fortunate that we do have a county Death Review Team that has been in place for over 20 years and it may have a lot of historical data to say that this is a problem, a persistent problem that needs to be addressed. We also believe that community mobilization has been essential, as well as kind of a multi-specter collaboration. And we believe that our ability to end 20 years of disproportionality in African American child death would only be possible for public agencies and community partners within and beyond the African American community. We have confidence that we have the ability and the understanding to really make a difference and turn this around. Of course it will require ongoing political leadership to get to a particular crossroads. But I'll end by saying that we plan to keep the words of Nelson

Mandela as our guides for our force and actions: "There can be no keener revelation of a society's soul than the way in which it treats its children." All children. I will end there.

**COMMISSIONER MARTIN:** Chet, thank you so much and if you can hang on we'll ask for questions in just a moment. Dr. Canady please.

**DR. CANADY:** Thank you so much, Commissioner Martin. You know, I've sat and I've listened, as you have, certainly not as much as you have, but what a powerful moment in the time we're in. Dr. Elam mentioned about the voices at the table, and I look around at you and the community that you represent and I'm truly honored at the robustness of this Commission. This issue of disproportionality is not a new issue.

When I was a young researcher in the mid '90s, early '90s, this issue was being sprinkled about. The science is now irrefutable. And so I don't want to replicate the data and the statistics that you've heard my colleagues share. But what I want to do is to challenge you to think about how you think about the problem. I had the privilege of speaking last week to a group of church clergy from a cross denomination. And I kept thinking and hearing, come, let us reason together. It is going to require each of our lenses, each of our experiences and each of who we are to come to a decision.

Now, I'm a sociologist. Sociologists tend to be incrementalists. I am an incrementalist, but I'm a little impatient as an incrementalist right now. And so I just want to throw out a couple of thoughts for you. This book, which was published by the National Association of City and County Health Officers -- and you all know by my bio that I'm a public health professional -- we're honored in our county to have a chapter in there. And I used to share this picture and say, what do you see different? And people would talk about the color and one is looking up and one is holding on.

Now when I show this, people immediately say, well, their ladders are different. So that encourages me that we are making a shift as a national conscience. We're beginning to say that's not good enough that some people don't have ladders, but let's look at the quality of our ladders and why do some communities have ladders with a few more rungs. And we say, but what are we going to do about that as decision-makers. And it's hard stuff.

It's not at all simple to think through this whole big sociological model of where racism, where gender bias and oppression, where economics happen, we always want to go back to psychosocial stressors and unhealthy behaviors because it's easier. So if you're landing at a

decision and recommendations to the White House that seem easy, may I challenge you to push more deeply. These are not easy solutions. We have the capacity to address them. There are a ton of different metaphors out there now. Okay. Which one, which one?

This one I recently learned and was thinking about the Monopoly game that goes on and on forever so we don't often play it in my home. But my colleague said, so if we had six people that started playing Monopoly and they played about five rounds and then we added two more people and they played another couple of rounds and then we added two more people, who's going to win? Well, somebody from the first round and they're going to win from the first round because they got in there and bought up all the utilities and they bought up all the property and there's no way that the others are going to win. It's very much like that in how we unpack this issue of disproportionality.

A colleague, Howard Cohen, whose work I love is a researcher, and for me the question of how we get at this, we cannot get at this without being generally driven by a profound sense of mission and being willing to have a sense of purpose that motivates us to leave the comfort of the sidelines and to waive into controversy. You are waiving into controversy. And so we can do that in a way that is civil, that is honorable, that is respectful, but there's no two ways about it. It is controversial, so thank you for that. The question of who, the IOM defines public health as -- public health is what we as a society do collectively to assure the conditions for people to be healthy.

We -- look at all the collective pronouns -- we, society. This is not something that one of us can fix. As your colleague, Dr. Mattingly, testified here today, there's no silver bullet. There's no silver bullet, but we can, I'm convinced, come to this together. We've been toying around and I've been just thinking in my own mind about this issue of responsibility. Who's responsible? And we talk a lot in my own state of Michigan about personal responsibility. And typically, the sociologists push back and the public health professionals push back, but there are, I believe, three tiers of responsibility that we have to marry if we're going to be effective.

Certainly, individuals have to take ownership. Individuals have to be empowered and individuals, I would add, have to be given hope. We're not seeing a lot of individual personal responsibility because people are burnt out and hopeless. In comes then some social responsibility. How can we collectively, as a community, as a commission, engage individuals in a way that creates change? My son who's 19 and in his first internship this summer has his own apartment and he says, you know mom, it's really hard to eat healthy. All the stuff that's around my job is just junk. I said, I'm going to be a stud. I got my own apartment. I'm driving my car, I'm going to do the right thing.

It's hard for us. And then what even greater than that, which is the new thing I'm kind of toying around in my mind. Personal responsibility, I get it. Communities come together, I get it. But what is the collective responsibility? What do we do not just as a public sector or private sector, but public and private sector coming together to really change status quo, to welcome and encourage those changes to status quo? We are not going to be able to shift this descriptor of health disparities and disproportionality. We'll continue talking about it. Our children will keep talking about it if we don't take this moment right now.

Let me throw out a couple of ways you might think about your thinking. I'm going to start out with a really simple question. In public health, we talk about prevention, why do people smoke? Let's figure out why they smoke so we can get them to stop smoking. What we're suggesting now is perhaps we should also ask not just why do people smoke, but what are the social conditions and the economic policies that predispose people to distract them and encourage them to smoke? What about asking that question? Instead of just asking how do we connect isolated individuals to social support, perhaps we should also ask, what institutional policies and practices maintain rather than counteract their isolation from social support? There are many. I won't even go in on the journey of fathers who have a history of a felony and if their family happens to live in public housing, is it intentional? Absolutely not. It refers to my colleague, Dr. Wedding's, references most often.

Another example, what prevention programs will reduce the incidents of child abuse and neglect in our community or in our country? Let's ask that. But maybe let's also ask, how do our institutional and our interpersonal responses to child abuse and neglect perpetuate oppressive attitudes toward people of color and people living in poverty? How would we improve economic and living conditions to reduce the likelihood of children being abused in their home? That's the depth of the question, and we're not going to get to resolution until we pause and ask the tougher questions. It's not about allocating more money for more programs. A question of what?

So a couple of examples, I have the privilege -- and you heard from Mr. Hewitt about the great work he is doing out west -- I have the privilege at the Michigan Public Health Institute of recently beginning a partnership with major community services in Detroit around a model called Transitions to Success. And she, my colleague, Dr. Marcella Wilson, who is a social worker by training, talks about, it's really interesting that if you're treating diabetes, you don't go change, like, every doctor's office, you have a standard of practice that gets shifted, you roll out those new standards and people begin to do their work differently. Somehow or another in human services we're not doing that. We do that somewhat in public health. We do that in some other fields, but we don't do it as well in our human services, so how do we create a standard that's replicable in Michigan, in California, in New York that builds a sense of accountability and ultimately benefits, as we said, all communities, but particular communities of color which are waxing behind.

Our motto of health equity and social justice challenge is not just, oh, here's racism and this is terrible. Yes, we understand that there are different levels of oppression and racism and bias, but there are also levels of change, so yes, we know that interpersonal racism, but we also know that interpersonal levels are where change and benefits happen as well. We know that structurally, there are changes that can happen and so we have expended -- I dare not say perfected -- but we've got a lot of practice in using a model called a facilitated dialogue where we really engage people at a very authentic place, both head and heart, to say, why would I as a professional endeavor to do this? So there are lots of opportunities out there and I just want to close with I guess three recommendations. Consider this shared model of responsibility.

I always said that if I remained a researcher at Michigan State University where I did work on African American infant mortality, I was going to stop asking why are so many black babies dying and start asking how are any black babies surviving. How are any Native American

babies surviving on reservations where resources are so deficient? How are our Latino kids surviving in gang invested communities? They are. Maybe, just maybe, we can figure out what's working and replicate that.

My second recommendation to you, change the narrative. If we continue to talk about vulnerable mothers, then we will continue to see the mothers as the problem, instead of about moms who are living in inadequate communities or communities that lack acceptable resources. We've got to stop problematizing individuals. Believe me, nobody wants to live in poverty. Nobody chooses poverty.

Thirdly, see poverty as a condition and not as a character flaw. We changed the poverty -- the national poverty levels. Those changed. We studied them and we shifted them. That means they are malleable and we can change our attitude toward them.

And lastly, let's push towards some standards and some shared replicable norms about how we engage families. I am a scientist. I believe in fidelity of models, but I also believe that you implement models uniquely based upon the voices of the community, the strength of the community and the characteristics of the community. So I implore you, if I could, without sounding too dramatic, we have such a moment in time right now, I feel it in my own state, I feel it all the more passionately here in New York with you. I had the privilege of going last night to see Hamilton, the Broadway musical, and it reminds us of all the greatness of our nation and our founding fathers, what they intended for us. And having grown up in a military family, I raise my flag proudly because I know we can do it. I know that each of us who are privileged, and anyone at this table is privileged, and because we're privileged we have the responsibility to do better. And if there is anything I can do to assist you in your deliberations, please don't hesitate to call. Thank you.

**COMMISSIONER MARTIN:** Thank you very much. Ladies and gentlemen, are there any questions of our panelists at this time? Dr. Rubin.

**COMMISSIONER RUBIN:** I have been looking forward to this panel, so thank you guys for putting this together. This is a very well- intended commission and we're trying to advance national recommendations to try to prevent some of those deaths. And I always think about a lot of the recommendations we have, they all are well- intended and they probably will prevent a couple of deaths, but then I always say, and this is the way I teach child abuse when we're doing that, the child maltreatment pack at the Children's Hospital, what's the cost? When you extend the net wider, what's the cost?

And so I really look to this panel of experts to kind of help me think about, for example, data sharing, and I asked a question about data sharing, well, what would it look like if we shared all of our data so at the point that a child came into a child protective services, law enforcement was there, the school is there, everything else, but you know, the reality is if we had that law enforcement data regularly and there's already disproportionality in the system then we can end up with the same disproportionality just almost exponentially. And that's why I favored a more public health approach, because a lot of services from a public health collective area are more voluntary have been eliminated. So for example, if you design a program, let's say where you want to invest more infant home visiting services in an African American community as a place base strategy, well, that's great but better prepare for the

fact that there are going to be more reports coming in because it doesn't solve the problem of implicit bias. So I guess the question is, how do we do this when we try to withstand and in some ways tighten the quill's to protect children from slipping through the cracks? How do we do it in a sensitive way that doesn't result at the end of the day dramatically making the issue of disproportionality worse? That's my question to the panel.

**DR. CANADY:** I would comment that it may get worse before it gets better. It's sometimes worse before the calm and I would much rather see higher -- the deaths are not higher, our knowledge of the deaths are higher. And that's okay. There was one article that said did child abuse exist before 1965 or something like that when something shifted and when we were measuring and documenting, so I think it's okay. We can't solve what we don't know. And there are, we have the privilege at Michigan Public Health Institute of serving as the national center coordinating center for an RWJ project in partnership with Illinois Public Health Institute and it's called DASH, Data Across Sectors of Health. And are that's what we're trying to do. We're finding there are lots of issues around trust, around this is my data and what are you going to do with it and what's the collective benefit to it, but again, I think as the dialogue changes and as we take the time to build relationships -- I love it when people say DHS says, really, DHA has a mouth now? Who said that? Who can we call and talk to about it because we need to share some information with them. So I think continuing to push around sharing data for a collective good I think is a great benefit.

**COMMISSIONER MARTIN:** Thank you. I apologize. Please continue.

**DR. CANADY:** I also wanted to add that the point that I made earlier about the importance of being able to realign data I think is a significant consideration because if in fact decision-makers, from what I understand is that because there's no standardization in terms of how data is collected some of the assessments about risk is coming from people who are well-intentioned but they have their own perceptions and their own biases, and so therefore, I think that from my perspective that makes our data somewhat unreliable and we don't know what we're going to get if we can standardize that data so that we can look at white families through the same lens that we look at black families or vice versa.

**COMMISSIONER MARTIN:** Thank you very much. Chet.

**CHET HEWITT:** Of course we all know the issue around confidentiality is taken into this notion about sharing data. I also agree with my colleague's comment it might get worse before it gets better. And I think we are understanding the kind of known qualities is really important to our ability to be successful. As it relates to child death, you know, the notion that the data is reliable, and I said it is not perfect, I think maybe it's not as widespread as we think it is, partly because there's a major criminal occurrence and it's pretty well reported. We know where children are dying and we know that's actually happening. And some of us have deeper levels of knowledge for that. The other thing I would say is there are opportunities to really think about who bears what cost in the way of dealing with public and private partnerships. For example, not specifically with death work, the folks who have stepped to the floor to respond to that, a lot has largely been our healthcare sector. So try to work from let's say a general health to our largest providers, now there's safe sleep assessments for every child born in their hospital. And then any family deemed to not have a safe sleeping environment for their child will actually be given portable cribs for free. This is good community benefit

work given their mission to improve health and well-being in their community as well. So a universal approach, not simply yet, but clearly an idea that can actually improve or reduce the impact in communities and disproportional impact as well, so just a few things to consider.

**COMMISSIONER BEVAN:** Thank you. I appreciate all of your testimony. And Dr. Canady I'm taking your advice and I'm going to wade into controversy, because it's important. Your testimony raised several issues for me. One is that there's no question there's disproportionality in the child protective agencies and African Americans are overrepresented, but this population is also overrepresented among children who have died of child abuse and neglect. So I don't know what to do with that, but the population, the overrepresentation of African American children in terms of death is not totally due to bias, implicit bias as it might be, but it's not totally, disproportionality is not totally due to bias and I want to make sure that it's clear because a lot of people -- Dorothy Roberts for one, she scares me -- the way I see it, there are three main potential causes of overrepresentation. There's bias in the system. Okay. Then there's also that African American children are at higher risk. And then there's the underrepresentation, which Dr. Wedding you referred to, the underrepresentation of whites and the under screening of whites, and underrepresentation. I mean, so that contributes to the disproportionality because one person is angry; the other one is upset. Like they used to say in the West Side Story song, you know, Officer Krupke, I'm sick, I'm just sick, I'm just sick, I'm not crazy. I'm not a juvenile delinquent, I'm sick. So how do we -- I want to reduce the bias, but I don't want to lose any children. I don't want to lose more African American children because of trying to do these divided. I want to increase the screening of whites. So how do we do this?

**DR. WEDDING:** Can I respond?

**COMMISSIONER BEVAN:** Please.

**DR. WEDDING:** One of the things that I'm suggesting, because child death is definitive. It's just -- you can quantify that, so that is why I framed my comments the way I did, which is to say that I want to focus on the events and interactions that might be indicators that we might be going down that path. So then we can measure implicit bias along those pathways. I mean, so many of the comments of my colleagues suggest that the potential of implicit bias is at every decision point within and external to child welfare. It's like decisions about, I mean, there's just a plethora of examples that were presented today. I do think -- while I can't say that implicit bias causes child death, I can say that implicit bias weakens families. I can also say that implicit bias alienates families from the very system that's designed to help it. So we need to look at all the decision points leading to indicators that suggest that this family might be weakened and going down a path that might end up in a fatality.

**DR. CANADY:** I often use a "both and" model, it is both of what you mentioned and it is that there is bias. Dr. Wedding didn't mention this as a cause. It is a contributor and it's a complex web. So you're not going to be able to -- a lot of times with research you try to say, well, which variable is weighted the most? Where is our bang for the buck but we got to get something going, but it's very rare to find that bang for the buck? So we think about okay, for instance, implicit bias, okay, yes, what do we also need to be doing as we're doing that? And I just think we're at a point where we have to have several balls juggling at once and we don't

really want to do that, we just want to grab the one ball and throw it as opposed to dealing. Are there families that have significant pathologies in them, absolutely? I talk to many of them. I know the judge deals with them all the time. At my church, we talk to young women in very complex relationships, why are you letting him beat you, why are you letting him beat your child, your family is here, your church is here. Complicated reasons. But that's no excuse. So we've got to push on them and then we've got to get a system that allows for an exit strategy that where there's a temptation to do something or to sit in a bad situation, there is also a way to escape. And we don't tend to do that for young people. So what happens in the discourse, I think, actually is we just choose our sides and it's either this or it's that and if we can come to the middle and say, no, it is both of these. So let's talk about what concerns you most and then let's talk about what concerns me most and let's believe that the solution lies between us, because it does.

**COMMISSIONER MARTIN:** David, can I ask -- I apologize, Commissioner Sanders, is your question on this issue or another issue?

**CHAIRMAN SANDERS:** I'm going to change subjects. So go ahead.

**COMMISSIONER MARTIN:** Let's finish this topic, if you don't mind, before we switch subjects. Commissioner Covington.

**COMMISSIONER COVINGTON:** I think, I guess I want to add my opinion into this mix, which is, when you look at fatality data, let's say you've got a fixed number of 100 kids, you're right, you can't argue which kids have died or not. Within that number, there is real bias in how the kid's cause of death is described. So a child who drowns in a nice white suburban neighborhood is going to be a really sad story and a child who drowns in an urban canal, it's probably going to be thought of as having very neglectful parents, which is bias, and we know that. And I think that's a problem we have to deal with when we look at the numbers, but it's still, I mean, regardless of that, I think we still have to go back way upstream to think about why that child who died in the canal was in the situation they were in and look at all the factors that led the child to be living the life they are living, but it's really complex, so that's our charge. I mean, we know there's bias in the numbers. There's no question, especially when you look at neglect. But take it out of the bag and start looking way upstream and look at the collective response that really addresses all of these problems.

**COMMISSIONER PETIT:** Teri, can I just ask you as a fellow commission member, the point you just made about bias in that calculations of deaths, I agree there is some, but do you think it's equal? Because the risk factors within black children's communities is much greater collectively than it is in white communities because of poverty. Well, there's other stuff, but because of poverty. So I'm concerned that we make it sound like, well, it's all the same, everybody is losing their children at the same rate and it's equal. It's not equal.

**COMMISSIONER MARTIN:** Let me jump in here. So I think that that's a wonderful research question that someone should take up one day. I think when we talk about implicit bias, particularly in this area, oftentimes you will see the majority of children who are white, their death is attributed as an accidental death, whereas a number of black children in similar, if not the same situations, that death is classified as a neglectful death, but I would suggest to the audience, and more importantly to my co-commissioners, the issues that we need in order

to work on this concern for our black children is that there is an overrepresentation of blacks in foster care. We are concerned about CAN [child abuse and neglect] deaths both known to the system and not known to the system we know that there are more black kids who die nationwide; two, and that those deaths are attributed to CAN deaths, so our question, the issue for us is, what do we do about it? It doesn't matter why it happened -- and that's a research question that needs to be answered. I would encourage our nation to answer that question, but for our purposes, I would suggest and submit that it doesn't really matter the reason, it does matter though that we recognize it, we point it out, and most importantly, we talk about the fact that we can do something about it. We have programs that are starting to look at that and making some indent or some road into reducing that overrepresentation of our children dying in our country. And with that, is there anyone else on this issue in particular? Yes. Commissioner Rodriguez.

**COMMISSIONER RODRIGUEZ:** Well, on this issue, I love the quote that you put up because I think part of the issue and what Commissioner Martin is talking about is that we have a field who is responding, who is responding at the personal and behavioral level. They're not responding at the collective sort of, we're all in this together, we're going to engage families and communities. They're certainly not responding at the institutional level around, how do we actually address the policies that are putting families and children in jeopardy? And so we have a workforce that has not been trained to analyze the situation or to address the solutions in a way that would actually get us to where we need to go.

We have a system whose workers come out and they respond and they sort of, not at any fault of their own, people come into this work wanting to help, but it's at the individual level. So to me, the real question that I'm left with after thinking about your testimony combined with John Mattingly's testimony is this piece around how you teach people to long for the beauty of the sea, because that's what I think -- if we had that idea in our mind that every time we encountered a family who was struggling and a child who needed help, if we could see them, like I really want you to be healthy and happy and grow up to be, and so what are all of the things that are necessary to get you there, rather than saying I really want to make sure somebody doesn't kill you and I want to make sure that you take your meds and that you detox, it seems to me like you would have an entirely different response. But it's a workforce, in my experience, part of the only way to get people to even consider that that beauty exists is to create multiple opportunities for folks to actually meet the birth families and meet the children who are in foster care and to get to know them to see they can be healthy and whole and they are people just like them, but aside from that I wonder, do you have any ideas about how do you teach that longing in a workforce that has not been trained, they have been given the tasks and the duties of gathering wood, I mean that's all their paperwork and data input. So what can we do to get folks there?

**DR. CANADY:** That was the one thing I was impressed with my colleague's work in Transition to Success. They teach the caseworkers to do that so that when a family comes in, they don't say what problem do you have, they say, what are your dreams. And for one woman it was, I don't have any dreams, I just need somewhere safe for my kids to live. Okay. That is a dream, let's work on that. And they work on that. And after they solve that, it goes right back to the start, now what are you dreaming about, and so it engaged them, but even the caseworkers then feel more optimistic and more encouraged about coming to work. So I think it has great

promise, certainly in the private work that we've been doing, but it is just that, how do we get out of a deficit model to a resilience model and don't see people as defective, see systems as having problems and systems can change.

**DR. WEDDING:** I'd like to add to that that in the trainings I do across the country, one of the things that I say to judges and other practitioners, whether they be law enforcement or social workers, is that we learn information from both the cognitive and affective domain. We have to move people into the affective domain where they feel. That's where they can feel sensitive. That's where they can identify the children who are in care as being their children. And it's from that position that we're going to get the most social changes. That's in some ways, you know, sometimes people think that's not real science, but the reality, it's the humanness in all of us and that's what we share.

**COMMISSIONER MARTIN:** Thank you. Commissioner Dreyfus. I apologize.

**COMMISSIONER DREYFUS:** Very quickly, so John Mattingly told us there's no silver bullet. There's no one answer. This isn't easy. We could focus on disproportionality and child abuse and neglect and 20 years from now we'll still be having this same conversation as a nation. I want to just make a comment on implicit bias, because I think the multiplicities of things that have to go on in this nation so that my five year old and two year old and one year old grandchildren are not citizens of this country's implicit bias within themselves. We as a nation have to confront that implicit bias exists and there has to be some process of reconciliation for this country. And I was in Canada a couple years back hearing about what they did as a nation for reconciliation and it was absolutely beautiful. And recently in Charleston, a state legislator called for reconciliation. I agree there's a lot of technical things that we can do in child welfare to get underneath disproportionality. I get it. But I think we will do it and we will still be confronting this 20 years from now if we as a nation do not confront implicit bias is real, racism exists within each and every one of us in one way or another, and it is painful and it is hard and people hate talking about it and until there is reconciliation at a local community level, I fear that my grandchildren will be having this same conversation.

**COMMISSIONER MARTIN:** Thank you. Commissioner Sanders.

**COMMISSIONER DREYFUS:** Now change the topic.

**CHAIRMAN SANDERS:** Thank you. Thank you for the timing. It's perfect actually. Hopefully it's a question about what to do. I was struck, and it's directed to Chet Hewitt -- although really it's for everybody -- you mentioned the six communities in Sacramento and 80 percent of the fatalities occurring in those six communities, and you have now experienced obviously leading one of the nation's largest healthcare foundations as well as having been both the child welfare director and human services director, the strategies that you select in those six neighborhoods, would they be different if you were focused on reducing child abuse neglect fatalities versus reducing health disparities?

**CHET HEWITT:** Not entirely. There are some programs best practices that are more directed towards the idea of illuminating fatalities, but we see the fatality as a disparity in health outcomes for that community and for the children and families that are impacted more broadly as well. So rather than seeing these as kind of separate endeavors, we think that there is strong relationship to the idea of what drives health in the community, the kind of

social determinant, the environmental condition, the sense of, you know, hope and potential. And the factors that give rise to levels of stress that often push people to do things that they might not otherwise do.

As a former child welfare director, I make no apologies for bad people who do bad things to children, but to follow-up on my colleague's question around smoking, there are, we believe, environmental factors driven by a lot of the things that have been described, bias, people's experience with that, the trauma that parents they themselves carry based on their experience living in a society that has not dealt adequately with issues around race and class. That often results in higher levels of child abuse, neglect, and unfortunately, fatalities in those particular communities. So for example, one of the things that we think is really important is child reform care. The adverse child experiences that parents themselves have actually had. So to kind of get to the fatality question, we think there are a number of things on that. What we are trying to learn better and trying to understand better are, what are some of the activities or areas of focus that if you are able to address them, the spinoff effect will actually be more supportive, nurturing relationships, which will mean parents will have a sense of hope in their willingness and ability capacity to deal with the challenges of raising children. So for us, it is part of a continuing and not a separate set of factors.

**CHAIRMAN SANDERS:** I'll ask a follow-up and also if anybody else on the panel wants to address that. I would be curious as to your thinking about one of the things that we've observed or at least has been presented, and certainly anybody can correct me if I'm wrong, but it appears that the number of child abuse and neglect fatalities has remained stable, that it doesn't seem that strategies being employed have been successful in reducing child abuse neglect fatalities. At the same time, it appears that infant mortality has declined. Do you have any thoughts about why there might be a different impact on the different outcomes?

**CHET HEWITT:** Well, David, you know, this is something that we see in child welfare where caseworkers are with clients overall but the disproportionality remains consistent and our belief, which is driving our strategy, is that many of the things that we have done which have been important and successful have not adequately included community. And I'm talking about community in the broadest sense of the term. So as we go back to this work with very explicit directness to deal with reducing disproportionality, even if we work hard to reduce overall child fatality rates, we think another stage of learning and experimentation are required, and we think that it requires us to build capacity and communities that have not been built here before.

So for example, we talked about alternative responses differently. We're going to talk a lot about communities and cultural brokers in communities. We are going to work hard to include folks who may not pass maybe more traditional tests that would result in their inclusion in formal systems. They're not all going to be child welfare workers the same as we talked about earlier, but many of these individuals and institutions have great walkabouts in this community, real relationships with families that are based on trust and caring, which can't be replicated in a training session. So our intent is to unleash that capacity in the community, not simply see them as communities riddled with deficits but communities that have access to be unleashed, and we hope that that in combination with the changes that are being done internal in the systems themselves they will add real value and begin to impact that level of

disproportionality that has remained consistent despite overall drops in fatality rates across the counties.

**CHAIRMAN SANDERS:** Thank you.

**COMMISSIONER MARTIN:** Dr. Elam.

**DR. ELAM:** I appreciate that question as well. I think as we worked at the local level, we had conversations about programmatic responses being made available, accessible, and then doing an analysis to see if communities are actually utilizing those services, and I think we've gotten to a point where we are making things available and accessible, but many times what we have made accessible is not culturally responsive to the priority communities we are trying to address. For example, when we did focus groups in impoverished communities, they chose not to utilize things that we have made accessible and available because of the experiences they've encountered.

**COMMISSIONER MARTIN:** Break that down a little bit.

**DR. ELAM:** Breaking that down. My wife is here. She's a registered nurse and we were talking this morning listening to the conversations and saying if I engage a human service worker or a nurse and I feel belittled in that conversation, I'm not coming back. I would rather deal with this pain, this suffering rather than be exposed to that type of experience. And so there are informal networks being developed in our local communities that are being utilized versus these formal systems. And so I think the comment made earlier by Commissioner Dreyfus about the silver bullet, we now have another round of policies that say safe sleep is the answer. And you guys navigate an entire segment of the community that even believes in that or has bought into that.

And so I think if we're looking at the data, our policies tend to reach a certain segment of the population, but we are not doing our best work at engaging those who are disconnected from our formal systems. And if we're going to move the needle, I think that's where the hard work occurs, as Dr. Canady mentioned, we have to get out in the communities. Another example, when we do this local work, we see that there is power circles in the local communities as well. And some of those folks are not invited to the table purposely. And so we ask the question, you know, who is person on this committee that can engage the dope dealer and the person in the community that we don't want to touch. They don't want that representative at the table. So if we are going to develop effective policy and programs, that person has to be brought to the table to engage that that disconnected population.

**COMMISSIONER MARTIN:** Thank you.

**DR. WEDDING:** I wanted to add to Dr. Elam's comments because it's so critical I think for us to recognize that nobody at this table today is going to want to participate in something that is embarrassing, that's humiliating, where they are being judged or they are being degraded as parents, and a lot of people, you talk to people who are in communities who are interfacing with systems that they are uncomfortable interfacing and because of people biases, the assumption is that they're not good parents, we lost them. They are not going to come back. And so even though these are small nuances, this is precisely how biases work.

**COMMISSIONER MARTIN:** Well, ladies and gentlemen, I have one question that I'd like to have your opinion about. We've heard a couple speakers today talk about the community, coming to help our children and our families, really to help our children become more well. Dr. Barbot talked about it. Dr. Canady talked about it. Mr. Hewitt talked about it, but also you specifically talked about the faith-based community, and over the last couple of years we've had very few witnesses really talk about how to engage the faith-based community and what are we asking them to do, what do we need them to do. I'm wondering, can you give us some of your impressions about how that community can help particularly our minority children and families.

**DR. CANADY:** Well, I'm honored to serve as a minister at my own church, and so it was interesting this conversation I had because it was congregational folk talking to congregational folk and holding each other accountable. There's much in most of our holy books that call people to be accountable for taking care of, for helping others. And I think what we've gotten sometimes in trouble with is we've misinterpreted and we're always doing for. You heard about Healthy Families America. They have this wonderful slogan, which I don't know if they still use it, but it was do for, do with, cheer on. The idea was you build some capacity and then you're like okay, see ya. The bible says the poor you will have with you always, but they are not going to be the same poor families over and over and over again, right. How do we build capacity in people? So I think you have to find bicultural and bilingual folk, and by that I mean understand a faith culture as well as a secular culture and to have those conversations in an empowering way that holds each other accountable. I can't talk to the drug dealers but there is one that can talk to the drug dealer and hold him accountable. It is so much about relationships and relationships to this not just well meaning but actually well doing.

**CHET HEWITT:** I agree with my colleague's comments, more specifically during my time as the child welfare director and being director now in the county, we actually ran a safe initiative where we engaged some of the largest African American community churches in specific efforts to help us shape policy. It's the way we built sufficiency for reform relative to the board's decision that precipitated the IV-E waiver by training them about the nuances of child welfare. And I will say, it was amazing how little these institutions knew about what was happening to their children from how they were represented in the system itself to the challenges they were actually facing once they were engaged. They also provide, you know, an opportunity to recruit family environments, foster homes for kids, so it helps us reduce reliance on congregate care because of the large consistency who actually cared about our children. And we also found that a fair number of our foster families were also members of those institutions and several of them actually created fellowships to provide an extra layer of support for families who were sometimes dealing with children who had challenges born of their past experiences as well.

So those are the few things that I would say, but when I talk about unleashing the kind of talent, the capacity, the strength of community as part of the challenge of the disproportionately, whether it's around safety or reducing fatality or even from the things that don't cure all the ills in the system but make what we do have to offer families better, which is not the outcome -- we'd like to see huge reductions and utilization of course, but for those kids who find themselves in care in, you know, the best environments, family environments

are also important. So there are a lot of things that they can do. They have to be asked and included in the conversation and sometimes guided along the way so they can help figure out what's possible given the constraints they have as well.

**COMMISSIONER MARTIN:** Thank you. Commissioner Rubin.

**COMMISSIONER RUBIN:** I'm going to pivot a little bit because I recognize, Chet, in particular your experience in Alameda County. And you won't remember but I met you about 10, 15 years ago I think at a conference and you were describing the experience chasing the block grant in Alameda County and trying to re-envision the way that child welfare services were provided in Alameda. And I'm not here to talk specifically about block grants, but more about sort of this idea that how you move upstream -- how you reposition the types of services in child welfare and then when you look at the systems today, do you have advice to us based on your experience on how we might make it easier for this generation's child welfare directors to really reposition resources to help communities move upstream?

**CHET HEWITT:** Thank you for that. I didn't recall your name, but it's great to hear your voice again, and I actually didn't get to offer my recommendation, so I'll do that quickly in this part of the conversation as well. But just by way of correction, I took lots of flak for this over the years, you know, block grants are not indexed in our IV-E waiver, we actually had a two percent growth factor. David actually knows this. So I supervise what we consider to be a financial incentive to actually do work differently in communities as well and including communities in doing that. And being able to have a resource base to actually make the promise of reform financeable so that it could actually take place. It's not a loss for me, but there is a cost for this and there is no cost greater than the loss of our children and so we as society should prepare to bear that particular cost going forward.

And in direct response to your question, there are four things that I would actually recommend. Clearly a stronger focus on early intervention moving upstream and this notion of parent engagement and community engagement. They usually think child welfare is a residual or developmental system. I mean, three fourths of the system is residual, you know, it's about removal, adoptions, and placements. Family strengthening, which is the fourth leg, is also the most underfunded part of the system, and we have got to create incentives and policies to actually change that. Two, there has to be an increased focus on family development because ultimately, all child and family health systems are about human development and that is finding places where people are and trying to move them and their families to secure their children is an improvement.

And so there's this ongoing debate, are these two things related, I think it's going to be settled in a way in this country so that the standard conduct roles of the profession itself are different than they had been over the past 20 years. Clearly strengthen data connection, independent review of the causes and consequences of child fatalities or why kids end up in the system are important and it leads me to my fourth recommendation, which is this notion of broad use of validated assessment and screening tools to kind of clamp down on the kind of subjectivity that is expressed in the form of implicit bias and others relative to how kids and families are treated at key decision points in the system as well. I once had someone tell me that we were going to create our own screening tool. These are scientific instruments, these are not things where you just get a group of political folks together in a room and create. But

I can tell you in Alameda County when we implemented our FCM, we seen our intakes go from about 1300 a year to 600 simply because we were asking the question of what else could have been done for this family or what led you to think that removal of that child from the home was the best intervention possible. We have said to folks that you treat risk and you remove for safety. I think that we have got to get back to understanding that and doing the work and being courageous enough to understand what that actually means and removing and synthesizing the system in ways that promotes its use of that particular idea.

**DR. ELAM:** I'd like to add to the comment that was made about providing family preservation and reunification services. From the field, we constantly hear that we know what works, but we don't have enough of it. Waiting lists consistently for youth and families to participate in programs, so they're opened today, they're closed today, and you're waiting six months for the next opportunity and for some reason at the state level, those are the programs that are being cut. Concerning disproportionality around making those services available and our qualitative review, which speaks to the objective risk and need assessment tools that were just alluded to and I'll use that, quote, unquote, depending on where you're looking. We have found that reasonable efforts were provided more often for white families than African American families. So for the same behaviors, those evidenced-based programs are being infused to white homes six, seven more times before a child is finally removed where we have documented that for African American families, after one or two times, that child is being removed. So there is some discretion in that practice in itself. And so I don't know if it's due to the lack of availability of services, because we hear that, so when the funds run out, kids are being removed because now we can't address the safety issues, but if we invested more in those types of programs, I think you would see the numbers begin to move.

**DR. CANADY:** If I can make one quick comment on categorical funding. As a former local health officer, you know, categorical funding I understand the importance of that mechanism. It's a blessing and a curse. If we could figure out how to get innovation in that, I appreciate categorical funding being resourced around particular needs and areas, based on data, based upon documents, but sometimes the needs shift and then we don't have the flexibility to address needs because we don't have the mechanism. So I don't know if there's some portion of the categorical funding that can really be about innovation, you know, we want to see something new. This problem, if it hasn't changed, what are we going to do different.

**DR. WEDDING:** I have just a very quick two ideas that I wanted to just put on the table and I want to think in terms of a strategy the possibility of implementing at some place along the way, and we can apply this, something similar to what they used for the National Counsel For Juvenile and Family Court Judges used for just judges and that was the bench card, which is a little tickler, a little something to remind people to ask the questions that some of you just suggested, to remind people, did I treat this family the same way that I treated other families, to get individuals to start thinking more explicitly, more intentionally and consciously about their decision-making. So that's one thought.

The other thought is that when I think about structured decision-making tools, I think about, even with those tools, even though that was one of my recommendations as well, but I know that even with these developed tools, there is a place for discretionary decision-making. So we really have to monitor that. Even the best decision-making tool is not going to eliminate bias. It just cannot, because there's always a place for overrides. And in the example that you

just gave, it's like so, when you run out of money, it's like not everybody is going to get the same services. So then people start to use their personal discretion and decide who is more deserving.

**COMMISSIONER MARTIN:** Any other questions, Commissioners?

**COMMISSIONER COVINGTON:** I have a question a little bit. You know, I mean, race is a pretty hot topic in the news these days with what's going on with policing in our country, and I'm wondering how you feel we should address it in our report as we put it together. I heard a comment the other day, which I actually loved because they were talking about the controversy in terms of people using the expression black lives matter. And a lot of people saying well, all lives matter. And the person said well, when we're talking about global warming and we talk about the earth matters, we don't feel the need to say Pluto matters too. I thought he just made so much sense. But do you have some recommendations for us as we think about addressing these issues that have importance within your organization in our report.

**DR. CANADY:** I would thank Commissioner Dreyfus for her remarks about reconciliation. Somehow our inability to reconcile, and I think for many reasons we don't want to further complicate things. It's a hard conversation to have, but we've got to have the hard conversation. I say all the time I do this work because I'm going to be retired on a porch in my rocking chair and I don't want my grandkids coming in telling me what they had to deal with. This is legacy work. This is generational work and so I think the fact that you would address it openly to say that clearly -- and it's not just about race, it is about racism and the historical legacy that could be gone if we would address it. So I think with candor we talk very much in our facilitated dialogue about why we must address racism explicitly, even though it's hard for people whose families or who personally have experienced racism, they want to say I'm not picking at this wound one more time, I'm tired of it. And people in the majority, white Americans, feel like, here we go again getting blamed. It is a hard conversation for all of us, but I really do believe that without our caring enough about each other to have the tough conversation that it will continue to spiral. So I think putting it forth saying that this Commission recognizes that many of the challenges are based on race, even the science, when you control for poverty, socioeconomic status, there is still a variance that is unexplained and we believe that it's because of racism.

**DR. ELAM:** I think there's three things I'd like from the work. Obviously there's an issue of the stewardship and accountability and it sort of hurts when any elected official either stands up and talks about data without just aggregating the numbers. And if we had any public systems, it should be a system that benefits everyone. And if data tells us that there's a group that's not benefitting from a public system, then I think it's just the right thing to do from a perspective of accountability and stewardship. This isn't an issue of does it feel right or is it right, it's all kids should be able to thrive and when we identify those deficits, we ought to look at those issues. I think that the equity issue has now been documented and there's a business case or that our economy is suffering as a result of us not addressing these issues. And so we look from a deficit approach. That's one thing I think we are trying to shift, how are people able to be resilient in conditions. If we can learn more from that, I think we as a nation would be in a better place. And that's been quantified. But I think the reason we do this work, and I'm really connected to what Dr. Canady says, I think about my kids and my

kids growing up in a community and it is a social justice and an equity issue. Everybody is not going to rally around that, but I think if we create the context and change the narrative around one that's more related to accountability and us looking at the business page for our society and then looking at these equitable issues at the end of the day, then I think people will begin to understand. Some people just shut down when you start from that space. So that's our recommendation. And as we've looked at the work, those things have been the same when they start from those spaces. We've been able to continue and look at those models where when we start from a platform of social justice and equity, it is a much harder bolder to push up here.

**DR. WEDDING:** Well, I don't think I could say it better, but I think we all know as human beings that it's a moral imperative. And I agree we have to have admissions that I think needs to come from -- we may not get it from the top of the government, but I do think, I mean, this is probably not something that we can deal with, but I totally agree that we have to apologize and recognize that there's a historical context in which people are really suffering, and in some ways we're losing people. And so I think the time is now.

**COMMISSIONER MARTIN:** Chet, do you have anything to add, sir?

**CHET HEWITT:** I missed part of the question a little bit because my phone -- my battery is dying. If I believe I caught the gist of it, it relates to the movements that you see happening, I think they are a direct response to what we have not done. And it suggests to me because, you know, part of our community mobilization efforts actually use a chapter of black lives matter and is actually engaged in it, and if I must say, this is not simply about contestation, advocacy in a traditional sense, not that we're against that. It's all about social justice, it's all about cultural justice kind of mandated the foundation, but what I would add is that it is also part of building that sense of self-efficacy that individuals and communities need about their ability to influence that democratic process we're talking about. If you can make your needs heard and you can expect and sometimes demand that there is a response. And when people have the experience of seeing that in fact happen, because we just had it here in Sacramento. I think it is an enormous and powerful jumping off point for the types of change that we're talking about to move forward.

**COMMISSIONER MARTIN:** Ladies and gentlemen of the panel, I want to thank you on behalf of the subcommittee and on behalf of the Commission as a whole. Your testimony has been well received and well appreciated here. Thank you so much for your time and effort.

**CHAIRMAN SANDERS:** We're going to take a break.

(A brief recess was taken.)

**COMMISSIONER RUBIN:** So I'll turn it over to Teri in just a second, but I would say we worked through our strategy in the military subcommittee was really to engage and I think it's an appreciation that military culture is different than civilian culture in that you have to be very respectful of the work that actually goes on in the military and in order to generate recommendations for this group, there were specific opportunities, but we wanted these recommendations to be driven from the folks who are doing this work every day in the military.

**COMMISSIONER COVINGTON:** So we decided to go through the route of the Department of Defense Family Advocacy Office because they basically have the official charge of studying and responding to child abuse fatalities in the Department of Defense. So there was a Department of Defense directive, I think this was in 1998, that required all of the services which is Army, Air Force, Navy, Marines to conduct fatality reviews of domestic violence cases in which a fatality occurred as well as child fatality cases in which it's suspected that child abuse or neglect had occurred of children of active duty soldiers. So that's kind of the charge of the Family Advocacy Office. The Office of the Family Advocacy Group in military, they're under the Department of Defense unit that really looks at family readiness and community living. So it's really a whole cluster of family services from which military families can benefit.

So the Office of Family Advocates is the office within the Department of Defense that manages what you would call the child protective services division in the military, which is the Family Advocacy Office, so to speak. And so they do assessments. They do referrals. They do substantiations for abuse and neglect of kids of active duty soldiers, but they also do the domestic violence support services in the military. So we went to them. I have been working with them for a number of years because once a year they bring on what they call a Child Fatality Summit where they bring all the different family advocate branches to the military together for a day or two in Washington and they share their findings from their individual reviews. So the Air Force shares reviews. The Navy shares reviews. And the Army shares their reviews. And so does actually the Marines. And they've done some pretty remarkable things.

For a number of years they would just share their findings, which tended to be about 80 deaths a year that we reviewed. The Army reviews them at the installation level, which is the base in military terms. They are supposed to review them at the base level, within the command structure on bases. But the Air Force and the Marines and the Navy do them at the national command level. So once, twice, three or four times a year, they'll do that for the meeting where they'll review all the deaths that have come to their attention. And they identify a lot of issues and that's one of the reasons we decided to go through them as sort of where we thought we would get the most information.

The other group that we wanted to go through they've -- Commissioner Rubin has done some of work looking at some the research he's done, and you'll talk about that in a bit, so what we did is it's a mixed system in terms of the people in the DC office or the Arlington office are civilians, civilian employees of Department of Defense, but the people within the branches tend to be active duty soldiers, well, soldiers, sailors, whatever, airmen. So we put a series of questions to them that we kind of -- we actually worked on a series of questions with them and then they distributed those questions out to the different branches. Things such as, what do you see as some of the biggest impediments to your being able to identify and respond to child abuse fatalities in their units. We heard from a number of people that one of the biggest problems that people feel happens at the installation level is that command changes a lot. So there's always, always movement, sometimes every two years, sometimes more often, of command. Every time the command changes, everything changes because those guys have a lot of authority and influence in how things happen.

We also have heard a lot that there's a real reluctance to address child abuse fatalities within the military because it's a career ender for soldiers if there's even an allegation of abuse and

neglect. Sometimes even if they are not founded, it can really ruin a career. And so not just the soldiers, but their spouses and family members and even commanders have a reluctance to report and then we also heard that there's huge problems between the civilian CPS world and the military CPS world with the installations and communities and that turned out to be the number one problem that we heard over and over and over again and that's probably the number one thing that they have asked us to address. We heard it -- we met with them while you guys were in Wisconsin, that's why I wasn't in Wisconsin. They met for an afternoon with us to sort of share what they thought would be issues that they would really like some attention to.

Without question, the number one issue is confidentiality and information sharing and exchange between the Department of Defense Family Advocacy and civilian CPS. And it actually goes in one direction which is that the military is required to share information with local and state CPS as part of their directive. When they have a family that lives in communities, they share that information. Only three states have any legislation in place that requires that information be shared in the other direction. And you'll share your findings, but by and large, they don't think -- they think they're missing an enormous percentage of their own families that are involved in child welfare because it's not being reported to them. And even when they know of a family of active duty and they're pursuing actions, whether it's services or substantiated or whatever, they oftentimes have really serious problems getting information from the civilian CPS world.

Some of the comments that they shared with us were things like, we're not going to share that information with you because you're an employer, just like we wouldn't share that information if the guy worked for General Motors, we're not going to share it with you either. The military is not seen by states oftentimes as these really huge service systems. We have been impressed with the array of prevention services that are in place for families at most of the installations, regardless of whether you're the Air Force, the Navy, or Marines or the Army, there's a lot of really good prevention services in place.

The other thing that really, really impresses me is when they do reviews, they have a really quick response in terms of submitting their recommendation, and that's partly the military culture, right, all they need is somebody to command that it's going to and it happens. So that tends to be what takes place. The Air Force had conducted their review of their fatalities three or four months ago.

They made a series of recommendations when they presented last month. Every one of those has already been implemented, so it's pretty remarkable. But when all is said and done, the biggest thing they asked for us to do, and we have some minor recommendations as well, but the biggest one is that they really asked for us to think about whether we could create some federal traction around requirements that in the event of a child abuse or neglect allegation or request from the military to civilian CPS that that information has to be shared. That information exchange has to happen. They really asked us to think about doing something that would legislate that. Because right now what they're doing is they are trying to change every single state law and that's going to take a very long time.

**COMMISSIONER RUBIN:** My center has a contract with the U.S. Army to investigate the relationship child abuse reports, diagnosis to deployment cycles of the military as well as

looking for linkage between -- the linkages to Family Advocacy Programs of children who are suspected victims of child abuse neglect. I will tell you that our understanding, this is my experience, and then I'll talk to you a little bit about how my interpretation of the data as we shared it with them. The fundamental understanding of child abuse neglect within the military is a lot more challenging for all the issues that Commissioner Covington said.

What we did is we looked at sort of Family Advocacy reports on children during the last decade when there was an increased operational tempo. Our fundamental understanding of deployment at that time was limited to only a couple studies that demonstrated that there was an increased risk of maltreatment, particularly neglect-related maltreatment, during deployment that likely was the separation issues and lack of supervision that was as a result of deployment. So there wasn't much more out there than that. As our data gets better it is going to demonstrate that during that time there was an extremely high risk of very serious medically documented high-risk injuries to infants in the six months that a soldier returned home from deployment. So it may be to an extent, but it was important to demonstrate that and we went into it agnostically and found that for both the folks that were singly deployed, the multiply deployed group, which is smaller but important, didn't quite have that, but with multiple deployments, the risk of serious harm went up and so that's just that sort of stress that, that hero stress with multiple deployments over time and the discussion around that is really around their deployment of resources, when and who and how can they actually deal with it, instead of providing services for everyone, can you prioritize returning soldiers who are coming home to a home with infants, right.

Now with respect to, what we do, we received testimony in El Paso with respect to that issue. The Family Advocacy Program where there was a really novel collaboration between their military and civilian authorities there and they had a significant reduction among military families and the risk of fatality because of its integration of sources and its sharing of information, and the testimony there -- and we probed fact on this testimony -- the testimony there was that they had made a lot of moves because the particular commander on the installation was very focused on the issue of family safety and well-being and that her concern was that that could change with the next commander who rotates on to the installation should there be a standardization program.

And so we asked that question of fact and the different branches and it was interesting what they said, actually, there was a kind of resistance to standardizing, this is the program at this time. And I thought it was for a very good reason because every installation has its own culture. And I thought of it in the same way we're thinking about the states. It's like the feds coming in and saying, you states must do it this way, but it creates an opportunity and we're going back, what if it wasn't you must do X or Y but every installation has to develop a plan for how they position resources to support a family and give them a lot flexibility based on best practices, but then let the Air Force and the Navy and this installation within the Air Force, Navy, the Marines or Army really have the flexibility to know what systems that they had locally and if it's on their plan but the accountability comes not everyone has to have a plan. And so we can veer what we're doing on the civilian side on the military side.

The second major issue is this issue of linkage, and so you know this issue of -- we actually identified medically diagnosed child abuse cases. And we're working with a child right now, this is from Tricare Health -- Tricare is health insurer for the U.S. Military. So you have a

single-payer system, right. It's basically a single-payer system, right. It is a single-payer system. And so that's also why I think that's why they're able to move policy so quickly when they ordain that. And the idea was, let's take a look at medical plans for child abuse of U.S. soldiers and the U.S. Army during the last decade. And where there were diagnoses of shaken baby syndrome and child abuse, these were physician-identified child abuses and high-risk injury cases, and asked what portion of those cases were actually known to the Family Advocacy Program in the U.S. Army. I can tell you it was less than one in five. So this was not shocking to the folks in the room.

Now, it doesn't mean four and five kids or more are not being identified. A lot of those kids are probably known to CPS authorities and that information flowed back to the Family Advocacy Program where there are a lot of rich resources to help families, right, to help their families, but they're not -- it's not happening, but there's also the potential, because these children move a lot, that we don't know what the true under recognition is, nor do we at a federal level have a linkage or an accountability where we actually link our fatality reports annually. Our death certificates actually ask, what's the actual infant mortality rate among the infants of U.S. Military members versus civilian. So that doesn't exist systematically in terms of accountability.

So I think the recommendations that came out were clearly it's impractical for every installation to negotiate some MOU around data sharing. It's a huge risk to children that family advocacy is not able to position resources when we don't know about children who are at risk. Every branch consensus would like federal action to actually not only create requirements or enforce requirements around change of information and the identification of children, but I think there's an accountability here too where there's some level of enforcement and auditing civilian child welfare systems to actually see whether they've reported back on military kids over time with potential penalties if they're not.

And so I think that this is a huge opportunity for the Commission. I think there's other ways at a federal level we can get a better idea of accounting for understanding how much of a risk there is and I'll say that the linkage issue also means that the data that comes out from the Army Central Registry or from the Central Registry of the U.S. Military about what the rate of child abuse is really suspect. We don't know what the rate of child abuse is because we don't have the full context of all the reports that we need.

**COMMISSIONER COVINGTON:** Again, on that note, we had heard in Colorado a professor make a comment that children of active duty soldiers are dying much higher than the general population and we could find nothing substantiative to verify that, we're not sure that's even true. But the back office doesn't believe it's true, but it's really hard to get to that when you don't have a way of counting that at all. So what I wanted to note is we did hear that.

**COMMISSIONER RUBIN:** Unless we do that, kind of look at a very basic level to look at morality, we're not going to know.

**MS. DREYFUS:** A clarifying question. On the CPS question about them wanting to have a more intense relationship with civilian CPS becoming a requirement, first clarifying question, are we talking about those families who live on the base or those families that are also living in the community?

**COMMISSIONER COVINGTON:** Both. But the person or the caregiver is an active duty soldier working on the base.

**MS. DREYFUS:** Okay. Marilyn, you'll have to forgive me, I in no way am likening this to the sovereignty of our tribes in Gaigwu, but I'm trying to create some parallel here in terms of what would be needed. Is it that the armed services believe that their active military should be treated as if they are in a separate and distinct community, class, different --

**COMMISSIONER COVINGTON:** No. I don't think that.

**COMMISSIONER DREYFUS:** -- where civilian CPS would be required to notify them?

**COMMISSIONER RUBIN:** The analogy holds to the extent they actually have -- they have resources. And that's the one value in the U.S., The military has physician resources on every installation for family advocacy and we're not utilizing them if they don't know about which kids are at risk.

**COMMISSIONER COVINGTON:** Not only that, but they actually do have a system in place where they are supposed to follow through, especially for a child with an active duty soldier, they have an obligation to run that case through their own child abuse registry and manage that case.

**COMMISSIONER DREYFUS:** So right now, it's dependent upon whether or not they happen to have the right relationship with the civilian CPS that agrees to do it, right now it's completely voluntarily and at the whim of local relationships?

**COMMISSIONER COVINGTON:** Yes. And in a number of states that have significant military population, the states have emphatically said we will not give you that information, we will not share it with you.

**COMMISSIONER BEVAN:** No questions. No piece of paper have I ever seen on the subcommittee and now we're hearing recommendations?

**COMMISSIONER RUBIN:** Well, we're not making recommendations.

**COMMISSIONER BEVAN:** I didn't even know you were having meetings.

**COMMISSIONER RUBIN:** Actually, we disclosed that there was no subcommittee. We actually reported that at prior meetings --

**COMMISSIONER BEVAN:** Yes, I know. But there was --

**COMMISSIONER RUBIN:** -- that we were meeting with FAP and we talked about our approach. We're just sharing with you today what the nature of that conversation is. It's our job as a full committee to understand. Now the question about testimony, we just didn't have an opportunity. There was no time left. We wanted to put together a panel just like we did here. We just didn't have time. If we have another meeting, we can bring a panel from FAP.

**COMMISSIONER COVINGTON:** They weren't able to either be in Wisconsin or here today. We're not putting any recommendations.

**COMMISSIONER BEVAN:** I think it's a problem, I just want to release that because we don't have anything in writing, and I don't know what -- you know, we're supposed to be as a commission looking at issues and some of this looks like we're supposed to be taking, you know, some staff is coming up with themes based on other, you know, hearings that we've had and you had, you know, you had one --

**COMMISSIONER COVINGTON:** We're really in the infancy of this because we only met with them -- it's been two weeks that we met with them. So we're very much in the infancy. I mean, this is just the beginning. We put a half an hour on the agenda to talk about it today. We are going to come to you with more information, but we really just wanted to bring this up as minimally as --

**COMMISSIONER RUBIN:** How many people went down there for that meeting with you, you had all branches of the military down there with you, right?

**COMMISSIONER COVINGTON:** Um-hum.

**COMMISSIONER RUBIN:** So she did -- we're doing the best we can in terms of --

**COMMISSIONER BEVAN:** I haven't but -- I -- you got to involve the rest of the Commission. Otherwise you're getting, you know, you're getting isolated then.

**COMMISSIONER COVINGTON:** That's what we're doing right now. We were working as a subcommittee, two of us that volunteered.

**COMMISSIONER BEVAN:** I don't understand what's going on. I'm sorry, is it just me? I don't think so.

**COMMISSIONER RUBIN:** We'll put it into writing and you can see the recommendations that were made.

**COMMISSIONER BEVAN:** Yes, and the questions you were asked okay.

**COMMISSIONER RUBIN:** Yes, we'll put that in writing.

**COMMISSIONER COVINGTON:** They still have that though under review so they really didn't want us to distribute that yet in case they're still working on it. I mean, the military, we have to really be respectful. They have a huge command structure. I would have loved to have shared their fatality report with you, but we can't even share it, so that's where we're at with them.

**COMMISSIONER RUBIN:** We'll get you -- we're working in that direction. Nothing here is final. We're just trying to give you guys context for where we are as a group and we will put that in writing. It's something that we used for CMS and with other groups that identify particular issues and we have to be respectful in how they want to work through this.

**COMMISSIONER BEVAN:** Just asking for advice from the chairman.

**CHAIRMAN SANDERS:** At this point, this was a report. We should have something in writing for the report and so that would be produced afterward and we'll have a chance to review it and the recommendations will come later.

**COMMISSIONER COVINGTON:** Yeah. I mean, for example, the analysis he was just presenting hasn't been vetted to the military for release. There's a lot that really has to be vetted by them before they're comfortable releasing it for us, for the Commission.

**CHAIRMAN SANDERS:** So they haven't provided anything to us in writing at this point, is that what you're saying?

**COMMISSIONER COVINGTON:** I have some really basic PowerPoint slides that they presented at the meeting, but I'm not sure that they really -- I took them, but I'm not sure I was supposed to.

**COMMISSIONER RUBIN:** It's a little bit complicated. I do want to acknowledge it's a little bit different. It's complicated. Whereas we can see community input to make recommendations to our commission, these are employees of the U.S. Government, right, and so to the degree that we're trying to identify systematic issues, I had felt it's a little uncomfortable to think that someone is going to come here and testify to us and provide a formal recommendation who's a current employee of the U.S. Government. I don't know who -- and particularly in the U.S. Military in the chain of command, I don't know the issues, but I sensed a reluctance and a reticence to do it in a very formal public meeting.

**COMMISSIONER MARTIN:** I think though we need to have a basic conversation about, as a commission, what information and where we can pull it from. So I understand what Commissioner Rubin is saying, but I'm not sure -- if we talk about our process was to take testimony, right, we can take testimony written, oral, we've already talked about that, but I think there has to be some way -- so either, you know, like, let's say I'm the sergeant of whoever you're talking to and you say Sergeant Martin gave me a report and her recommendations regarding fatalities or working in state agencies around child fatalities is xyz, you can submit that as testimony --

**COMMISSIONER COVINGTON:** And I'm assuming that within a month we'll have that.

**COMMISSIONER MARTIN:** But I guess my point is, what I'm trying to say is I think we do need to have something from the military as opposed to you two non-military --

**COMMISSIONER COVINGTON:** I agree. I'm not --

**COMMISSIONER MARTIN:** I thought we were just kind of working through it and thinking through it. So that's what my recommendation is.

**COMMISSIONER COVINGTON:** That's where we're headed.

**COMMISSIONER MARTIN:** Okay.

**COMMISSIONER COVINGTON:** It takes them a while to get anything clear. We just wanted to share with you where we're sort of going with that.

**COMMISSIONER RUBIN:** And what we sense is the nature of their deliberations, so ultimately, the responses are going to come from FAP, not us.

**COMMISSIONER DREYFUS:** If I can inject one more thing for your committee to take into consideration when you're doing your work. And I appreciate this, I view this as an update

today. So the whole issue of PTSD. They are doing such tremendous work on PTSD in the military and we know from the average childhood experience and sciences that happens with extreme cortisol levels that you get many of the same symptoms of PTSD with high ACEs and trauma. And then I was reading the work the staff had given us on caregiver mental health and fatal child maltreatment, and there's a number of research that talks specifically about PTSD. And I was just wondering as you guys are doing that work, yes, it's informative for military families, but it's the work the military is doing on PTSD that is potentially informative to us larger. I get to the Commander's question about triggers. All the sudden when he's talking about triggers that happen, I think PTSD research could help inform work beyond military families.

**COMMISSIONER COVINGTON:** I'm not at liberty to disclose, because they had asked us not to, but I know that when they come back to us they do have some data on the deaths in families that involved PTSD as a factor.

**COMMISSIONER DREYFUS:** Okay.

**COMMISSIONER COVINGTON:** A lot of it does say to look at after and during deployment while one soldier is away and the other caregiver is home and pretty isolated.

**MS. DREYFUS:** I was just referring to the work, I know when I was in Washington State, the VA out there was doing a lot of work in their behavioral health side on PTSD. They were doing a lot of testing, a lot of research understanding PTSD and I just think it could be really informative broader than military.

**CHAIRMAN SANDERS:** We obviously, when it gets to recommendations, we look to something in writing, are we anticipating a time frame? Were you saying within the month?

**COMMISSIONER COVINGTON:** I would hope within a month and I think they did too, but you never know because they do have put everything up through command. I will say though that the undersecretary for this entire unit at the meeting, the next day, not the meeting when we talked about the Commission work but the next day when they had the Child Fatality Summit come in, and she made it very clear that fatalities is a very high-level priority for that division of the DOD.

**CHAIRMAN SANDERS:** So today was just sharing the information, you don't have anything further in writing at this point. Anything else that we need to go over? Any other questions?

Okay. So we've had several requests to summarize the testimony that's been provided over what we have as for the first nine hearings. The last one in Wisconsin was not yet part of this. That's in the very last tab. The other tabs that includes the themes that were presented by those testifying in front of the Commission and I wanted to go through this to both see whether this is -- this can be supplemented by the minutes, which are much more detailed, but this captures some of what the Commission is most interested in and so I asked Amy and Sarah, I believe, to take a few minutes and just walk me through the methodology and what we have here. The recommendations qualitative review.

**AMY TEMPLEMAN:** Good afternoon, Commissioners. What we were asked to do by a few commissioners was to take a look back at the verbal testimony over the course of the commission's public hearings and see if we can identify any themes that came up again and

again and we thought that talking about it today was good timing for you in light of your review of recommendations tomorrow and also looking at the national strategy. So Sarah is going to talk a bit about the methodology and how she and her team approached this and then we also have some questions to sort of initiate a discussion amongst you about the content of the recommendations.

**SARAH ZLOTNIK:** First let me say, this is a collective effort of many people culling through 70 plus pages of testimony to reduce this and so I want to just recognize the many other hands in addition to the team that we have worked on this. So the process that it was that staff went through and culled down testimony of anywhere between two and 10 pages of recommendations varying quite a bit meeting by meeting. And then from that, that is what we looked at and we went through and I worked with a colleague of mine at Policy Lab and developed a set of codes where we both did them independently and then crossed them to get consistency and did the first four together and then my colleague put together what is a code list that you see.

**COMMISSIONER MARTIN:** Can you tell me who these people are? I mean, have we ever met these people? Do we know who these people are that pulled all this together?

**SARAH ZLOTNIK:** Well, Amy can speak to that.

**AMY TEMPLEMAN:** Right. So it was CPS staff who initially developed the minutes and edited the transcripts that fed into this document and then Sarah helped us identify some qualitative data experts at CHOP to assist in putting together the final documents.

**COMMISSIONER RUBIN:** We did this? I didn't know about this.

**COMMISSIONER BEVAN:** So now you know how it feels.

**COMMISSIONER RUBIN:** That's okay. We have resources and a whole qualitative research team and so my guess is that they did that.

**SARAH ZLOTNIK:** This was an incredibly labor-intensive process, so we did work on the first set of coding and transcripts and we reconciled all the codes. But we did have, to be upfront, we did have an intern who was working with us to do some of the coding. And I think, as Amy said, this is just, I think, was done to spark discussion and intended as a quick check, not to be any kind of --

**COMMISSIONER PETIT:** What did you find?

**SARAH ZLOTNIK:** It's in your handout.

**COMMISSIONER PETIT:** I know it's in my handout.

**SARAH ZLOTNIK:** What we identified were basically different mechanisms and different policy levers to go forward in terms of what they prioritized, whether it be state, federal issues, funding issues, or judicial issues, as well as a number of folks who put forward shifting framework, so what are ways that folks were charging the Commission to be thinking about this work from another perspective, so not necessarily specific content, and then content related recommendations. And so those were really primarily our information sharing, a more coordinated approach focusing on prevention and then, not surprisingly, focusing on data. The

documents are under the other tab, which is the final tab in your binder. And so it should be at the very end of the binder. There are two separate boxes. One is an overview and then one is more specific looking at each of the themes and the frequency of the themes. I want to add one other thing before we get deeper into the content. The purpose of the document was not to say, if you haven't come up with a bunch of recommendations around the most popular theme, that's a mistake. This is just to be one more tool and looking at the frequency from a qualitative point of view is just another way of cutting the data.

**MS. DREYFUS:** And you did send this out electronically to us last week.

**AMY TEMPLEMAN:** We did.

**SARAH ZLOTNIK:** Yes. They're only from speakers, not any of the comments by commissioners. Those were not looked at for this analysis.

**CHAIRMAN SANDERS:** Can you just highlight, especially for those in the audience who haven't had the chance to see the document, just what some of the themes are not necessarily those most frequent, just highlight some of the themes.

**SARAH ZLOTNIK:** Sure. So under the policy mechanisms, we had funding, we had federal recommendations, a lot related to forwarding CAPTA, to shifting frameworks, state issues, and then folks were making specific charges for how they related to how they wanted the Commission to respond or use their reports. Around the content it was much, much broader so we had --

**COMMISSIONER COVINGTON:** Can I stop you for just one second?

**SARAH ZLOTNIK:** Of course.

**COMMISSIONER COVINGTON:** When you say shifting issues, it's not -- I don't know -- it's not on our handout, so I don't know what you mean.

**SARAH ZLOTNIK:** Shifting framework. I'm sorry. It's under mechanisms.

**COMMISSIONER COVINGTON:** What does it mean? What does shifting framework mean?

**SARAH ZLOTNIK:** Sure. So I have all of the codes pulled up on my computer, but basically it was folks who were saying, so we need to reframe how we think about the public health response. So with all of those different frameworks where people said this is how we want you to rethink, you know, like, we got from the disproportionality panel, so I would look at this flag and say, well, what are the different ways that people want to think about this issue. And then everything is looked at to be able to say, well, what are perspectives that have to do with prevention and you can look at those together.

So to get to some of the other pieces. It's a lot related to family support, prevention, data, standardization, workforce, confidentiality, children in out-of-home care, front-end CPS, child advocacy centers, cultural responses, parenting training, predicted analytics, and we really primarily used our original set of codes that we've looked at throughout, so we recognize there are probably lots of themes that we missed or weren't captured, but again, this was just a first pass to try to begin to kind of cull the massive amount of data that you all have received. Would it be helpful to talk through any of them?

**CHAIRMAN SANDERS:** Let me just suggest, so one of the comments that have been made by commissioners over time is the importance of what we've heard from people and trying to capture that and that really is what this is. I think it's up to us to decide how we want to handle it and what we want to do with it and how we will measure each of the themes that have been identified. And I guess the first question for us in some ways is, do we believe this captures the themes? Do we want further discussion about even how they were defined? Because the themes are consolidating a number of elements that we may or may not agree with.

**COMMISSIONER RUBIN:** I think overall, I mean, as I look at this, seeing this document for the first time, first of all, we've had a tremendous amount of information and I actually applaud you guys, the staff, this must have been a lot of work. This is a tremendous amount of work. It doesn't mean you got it right, you may not have actually transcribed some of group conversations that we do. I think it's our job -- they're just trying to present information to us in a way that tries to recognize the volume of hits to certain issues. I think it's our job, those of us who want to prepare this -- if the lens to which it was interpreted was wrong, we need to clarify that. This provides just basically a menu for us to begin our deliberations and I think we have to really talk systematically, how are we going to deliberate.

**CHAIRMAN SANDERS:** Commissioner Zimmerman.

**COMMISSIONER ZIMMERMAN:** So just to clarify for me, and thank you guys really for really good hard work collating all of this tremendous amount of information. Of course you know where I'm going to focus is on American Indian issues. So I notice that, depending on the documents, there's going to be a chapter for American Indian issues. I don't see any mechanisms for themes, for example, in No. 2, page 2, No. 2, for key emerging themes, the federal issues, there's only one mention of collaboration of state and tribes. Almost all of the American Indian issues are going to be addressed in federal issues about sovereignty, and sovereignty probably needs to be a theme, even though I see it's not mentioned here. And then so I guess I'm wondering, you just took all of them or did you just exclude American Indian because you knew it was going to have its own chapter?

**SARAH ZLOTNIK:** I will say again we coded based on the first three -- because this was coded based on the first three meetings and then we used those codes consistently and so we got the tribal recommendations later. We have them, also one of the things that's really helpful is if there are particular things where we want to go back, we can easily pull any of that information out, but we didn't end up -- and I know that was one of the things that flagged for me as I was re-looking at this, so we should have pulled out a specific thing.

**COMMISSIONER ZIMMERMAN:** Okay. Because I know we as a subcommittee keep talking about our themes, which is data collection, sovereignty, infrastructure, services.

**CHAIRMAN SANDERS:** Did you have a follow-up, Judge Martin, to that? Or were you doing a follow-up, Commissioner Petit?

**COMMISSIONER PETIT:** Yes.

**CHAIRMAN SANDERS:** Go ahead.

**COMMISSIONER PETIT:** I'm just wondering and I think David mis-phrased it and I know we're all wondering about it, so I think we just should discuss it either now or tomorrow morning is at what point do you go through a yes, no, maybe kind of situation and both with respect to what a finding is and with respect to what a recommendation is? At what point do we actually tackle that in a specific way?

**CHAIRMAN SANDERS:** So we'll tackle that in more detail tomorrow, but the idea is to get enough of an outline in terms of the content that at a very high level that we think made some sense and begin to put some meat to that. Ultimately, we will need to develop specific recommendations and then we'll vote yes or no on the full body of the recommendations that we make. So we have a set of themes and recommendations that will be applied to a written outline, which has been done, which includes the chapters, so we'll have a discussion about that tomorrow. We'll have a discussion about what it means to hold the report together. And hopefully there'll be agreement, but if we don't then we'll open up and have to vote yes or no on even those kind of things, but the idea is to have something for us to actually vote on in writing and it continues to develop as we go forward with our conversations. So we're starting at a very high level and we'll get more and more details, and ultimately, if there's not agreement, we'll have to vote.

**COMMISSIONER PETIT:** But there is some additional fact-finding, right, there's been some research that's hasn't been pulled together. For example, on state budgets. That hasn't been dropped into a document yet. I don't know where that is, but there's a bunch of other things as well, so there's a to-do list I think.

**CHAIRMAN SANDERS:** We'll go through the actual outline for the report, that would be the kind of things to make sure is captured as part of the conversation.

**COMMISSIONER PETIT:** Okay.

**CHAIRMAN SANDERS:** Commissioner Rubin, is that what you were asking?

**COMMISSIONER RUBIN:** It's still really tricky I think because, you know, there's the interpretation of what these highlighted themes were. I'm just asking a more general question and it's, I think this is the tough spot, this is the pivot point, if you will. We're coming back together as full commission, and how is it that we want to create what I think is a vision for this, for our recommendations. Because now this is the interpretation part with all the different sort of ways we interpret what we heard. We probably all heard it different. And I think it's just worth a conversation because otherwise, I think, you know, some people may think what they heard were misunderstood, how do we arrive at some place to kind of anchor in and that's what I'm struggling with.

**CHAIRMAN SANDERS:** Let me go back for a second. So I think that how we handled these last few meetings will show you an example of what the intent is. And so we started with an outline that we had a lot of conversation about, decided that wasn't exactly what we wanted to do, came up with some general ideas about kind of what a first chapter would look like, second chapter, et cetera. And then we developed some outlines related to that. So that's what we are going to have more conversations about and keep having conversations about that as this gets honed in. We may end up at a point where we're simply not in agreement and then we'll have to vote on things, but it's trying to get more and more specificity so we

actually have something to vote on. Right now we have still at a fairly high level, but tomorrow hopefully... As a specific example, last time we had 10 themes of recommendations or 10 themes in regard to recommendations. And what was clear, what the comment was that's not specific enough, we need one thing or two things that we're kind of holding onto. That's part of what's been developed based on input since last meeting and we'll have a conversation about that tomorrow. Commissioner Martin.

**COMMISSIONER MARTIN:** So I think I need some help backing up a little bit. So a few meetings ago, I remember that there was a request for staff to put together all recommendations in the testimony that was provided to the Commission, and I've seen pieces of that come together periodically through e-mails. I guess what I'm trying to figure out, I thought then what we were going to do is take all the recommendations, the recommendations made by expert one through expert 25 and then we were going to put those in themes. So we were actually going to take the concrete recommendations and put in the themes that were already developed and we kind of agreed on -- where was that? Somewhere in another meeting.

**COMMISSIONER DREYFUS:** Utah.

**COMMISSIONER MARTIN:** Utah, and then from that we would then distill down into how we would come up with our recommendations based on the actual testimony. I didn't realize that staff was going to look at all of the recommendations and summarize them and then kind of put bullet points on them. I mean, who -- is there a commissioner that asked staff to do this or how did this come about?

**AMY TEMPLEMAN:** Um-hum.

**CHAIRMAN SANDERS:** I think several had made that request.

**COMMISSIONER MARTIN:** Okay. I missed that then. Then I guess -- because --

**CHAIRMAN SANDERS:** So let me back up and make sure I'm understanding. So you were thinking we would take the specific recommendations that came from everybody who testified and put that under the themes that we had identified?

**COMMISSIONER DREYFUS:** But just for consideration --

**COMMISSIONER MARTIN:** Wait, let me finish. I have the mic on now. Because what this represents is the staff summary of the recommendations. These are not the actual recommendations that we heard in testimony. And that's what I'm concerned about. I thought we were going to work from the raw data and then we as commissioners would take that raw data and then utilize that as the base for the foundation for our ultimate recommendations.

**CHAIRMAN SANDERS:** And I think that's -- so that's part of the purpose again of presenting this is that they made an attempt to kind of consolidate it because it is 70 some pages. We can take that, the raw data, and take a look at it individually. I'm not sure logistically I would choose to do that, but that really is an option for the Commission.

**COMMISSIONER MARTIN:** So I mean, I started asking for that like four meetings ago, and I wish we would have had a conversation because I've been kind of holding off. That's why when we

presented on the Native American subcommittee, we gave pages of where the recommendations came by, so if Rubin disagreed that I read that correctly, he could go back to the record and actually look at it and we can discuss if that's what actually the recommendation was that would serve as the basis for the commission's recommendation to the White House. So if I disagree with recommendation number one under funding, I have nowhere to go to show that exactly what I heard was correct as opposed to what Rubin heard was correct. I mean, this is a summary, not the actual recommendations.

All I'm suggesting is that's kind of why I asked what's the process a long time ago. I've been asking that, and the reason is, I feel it's imperative -- and I may be wrong and if I'm the minority in here, let me just get my position on the record and I'll stop -- but I think it's important for us to take the actual recommendations we heard from the experts. That's why we call them experts. That's why we ask for their time and their testimony. We take that raw data and develop recommendations that we think are appropriate to the White House and Congress. We can't do that based on someone else's summary of what those recommendations are. That's why I asked, starting three or four meetings ago, to give me each of the recommendations that were given. I don't need someone's summary. I need to read and understand where those recommendations came from in context so that I can make recommendations in the Commission.

**COMMISSIONER PETIT:** Pat, can I ask you a question?

**COMMISSIONER MARTIN:** Yes.

**CHAIRMAN SANDERS:** Hold on. There are a couple of others. Commissioner Covington. Commissioner Bevan.

**COMMISSIONER BEVAN:** Let me just say this, I have put in witnesses several times and I don't get the witnesses; therefore, I do not feel confined to witness testimony. I feel that we can look at the research, but I don't feel confined to witness testimony because there's a bias in how the witnesses are selected. And so we get a bias witness list. Then we get -- then we hear what they say and then we repeat what they say in their report, somewhat circular. And that's what I wanted -- and it's not a bias that's on purpose, it is implicit bias, not on purpose, but it's there. That's all I'm saying.

**CHAIRMAN SANDERS:** Commissioner Covington.

**COMMISSIONER COVINGTON:** Yeah. Going way back, it seems like forever and ever and ever ago now when we did the first set of recommendations around measurement and the way we did it was Rachel had taken all the recommendations we had gotten up to that point -- I don't know if you all remember, but she summarized -- she did a really nice paper and my thought was that's what was going to continue for the rest of the groups because we talked about that being the model, but she did a really nice summary of the presentations and what we learned and then she summarized the different recommendations that people presented, but we also assumed at the same time that that wasn't the world that we absolutely -- we didn't have to accept any of those, nor did we have to draw from all of those because we could also reach out to find other notes. So that was really nice as I was working with David and I and Rachel to come up with our early set of recommendations on our mission at that time we used it and it was really helpful to have it.

That being said, I understand the amount of work that you guys did. Personally, I don't see what you have created as being our marching orders for recommendation time, but it helps frame it for me in terms of what's out there so I'm finding this helpful, not in terms of what the actual recommendations were, but now I think I can go back and say, can you get me this little cluster of recommendations that you've now summarized for me here and that's how I'm going to use this document. And I think it's helpful as well.

**CHAIRMAN SANDERS:** Commissioner Petit.

**COMMISSIONER PETIT:** Pat, I don't think - - I thought I heard you say none of these recommendations would serve as the basis for our recommendations, they serve as a basis for our recommendations. I think if what you were talking about and I disagree with is just enumerating what all of the recommendations are in one place by subject matter so we see what they are. They can be as verbatim as you want. And you've got a database. I presume you could pull stuff up that you need, research and all that other kind of stuff, but what we're going to see is the expert testimony that we are considering, weighing, thinking about, evaluating, and determining whether or not it gets cramped into our documents.

**CHAIRMAN SANDERS:** Commissioner Martin, then Commissioner Rubin.

**COMMISSIONER MARTIN:** So Commissioner Petit, that's exactly what I have been talking about. You don't understand what I'm saying or we're saying different things.

**COMMISSIONER PETIT:** Maybe.

**COMMISSIONER MARTIN:** No. Clearly we're saying different things, because what I am saying is, I do think that the basis for our recommendations have to come from the testimony, either written or verbal. You can't have one commissioner read a report and then throw out a recommendation from that when I haven't had the opportunity, as a commissioner, appointed by the President, to question and to read it for myself and interpret it for myself. So the recommendations have to come from collective understanding and hearing and reading of the testimony or hearing it. We can't individually go out and Google something and put that in as a recommendation. We have to have -- that's the point of the testimony. That's the point of testimony, so that I could offer questions or ask questions so I could to make sure I understand the witness's statements or I can read it and then request that I bring in Steve Rubin to explain it so I understand it better.

The whole point of us working as a commission is so that we all have the same information from which to then make recommendations. And if you want to bring something to the Commission's attention, you have the right to do so. So if I tell Staff Sally that I want Joe Blow to testify and Staff Sally doesn't do it, I go to the chair. I go to David and say, David, listen, I really want Sally Sue to testify on xyz issues, and then we start looking at all the experts and the topics that they bring in and we determine if there were holes in the testimony. I thought we did that a couple months ago, that's why we had some people come in today, holes in the testimony that we need to get on the record, evidence we need to get on the record to draw recommendations from. So it's not -- my position is -- and I may be wrong -- but my position is that all the commissioners have to have access to the information from which we draw recommendations.

**CHAIRMAN SANDERS:** I just want to weigh in on this. Commissioner Petit, go ahead.

**COMMISSIONER PETIT:** We bring our own knowledge and experiences to this, and if we see something hasn't been recommended that one of us thinks should be recommended, we can put it on the table. Whether the group buys it or not is a separate question entirely. But I'm not going to be confined by what expert witnesses presented to us. We are going to evaluate a whole range of things, including our own experiences in this area. Whether people support it or not is a separate question entirely, but we're not confined to what we found at the forums that we've been conducting.

**CHAIRMAN SANDERS:** Commissioner Rubin then Commissioner Zimmerman.

**COMMISSIONER RUBIN:** I think I'm going to try to seek a resolution as I'm listening to what all you guys are saying and I'm actually agreeing with all you guys because it's about the process. One of the things I was going to say, if I was going to suggest a way forward, was I actually really liked -- I see this as a basis for interpreting themes that were made by comments. I don't actually see these as recommendations. Now we may decide that we don't like the categories of these, that they don't align with the reports so maybe we want to reorganize it a bit. But when I look today, it's like a menu. So we started with themes and the next thing for whatever categories we're in, take all the written and verbal testimony and actually list out the recommendation parts that were made by who made them within those categories so we can see all the -- so one is themes. One is actual recommendations that were made in testimony or in -- and so we can see a full recitation. The third category, and this is just the way my mind looks at it, is what information is missing still because we didn't have the opportunity, because there's only so much time in a day.

I think a lot of our not being able to schedule speakers was just because we ran out of meetings, right, and we all had all this information. This is not an easy task. But there may be stuff we asked that -- Pat, so what you're saying is that we may need to seek more information or make a direct contact because there's still a hole that's missing between the themes and the recommendations we received and actually part of our deliberations, what yet do we still need some information or ask a particular group to submit written testimony since we don't have any more public meetings. And then we have that menu. And if it's organized in the thematic areas that we want it in, then we can sit down and separately, we can also try to reorganize the way you present the full-length testimony by those themes or by some organization themes, so that if, Commissioner Martin, you want to go back and read all of the actual testimony verbatim, that is available to you as well, but this at least gives us like a playing card for which to then start to interpret as a group whether we agree or disagree. It's not going to be perfect. That's how I would probably reconcile all this, because I do think that that exercise is a good one.

**CHAIRMAN SANDERS:** Commissioner Zimmerman.

**COMMISSIONER ZIMMERMAN:** I agree with Commissioner Rubin and I do agree with a lot of what people are saying. I just want to make a comment on what Commissioner Petit said. We do bring our expertise, but I think I want to caution us that for myself, I bring a certain level of expertise, obviously, because of my focus on American Indian and a lot of key Native American issues, but I bring that expertise as the what questions need to be asked, not what

answers need to be given. The answers are coming from the field. The answers are coming from the testimony. The answers are coming from the experts that we invited to this conversation. I'm here to help formulate what those questions are. I think that's a huge piece of what is going -- what this commission -- what each one of us with our expertise, we knew how to ask the right questions or try to at least, because I don't want -- because she wants to know, as I said in the last one -- we walk through these commission meeting these federal statements or commission reports, federal reports will come down the pike and it has nothing to do with the audience or the people we are trying to serve because we are bringing our own biases and our own agendas to the conversation. And that's what I don't want to do as a commissioner. I just want to caution us on that.

And so I think having to say what I hear Commissioner Martin and Bevan talking about is it's got to be related to the testimony. We have got to have heard explanatory testimony. And if you and -- Dr. Rubin, Commissioner Rubin, and Commissioner Covington heard it in a private session or if I heard it in a private meeting with OGB or DIA, I think that's relevant, yes, absolutely, but it definitely, in my opinion, has to come from the experts in the field. It has to come from Americans. It has to come from those people that know this work and avail them that my agenda or my expertise is all about helping frame it, nothing else.

**CHAIRMAN SANDERS:** Commissioner Rodriguez.

**COMMISSIONER RODRIGUEZ:** So I just wanted to weigh in and say, practically speaking, I'm not sure we're really arguing about anything. I mean, I'm just not convinced, maybe it's because I'm a lawyer, but I'm not convinced that we couldn't make a case that anything we recommended was based on something we heard over the course of the past year. It seems like saying that our recommendations have to be -- I don't hear anybody saying that a recommendation has to be a recommendation made by one of the speakers or the panelist that we have to verbatim accept. It sounds like everybody is saying it has to be in some way based on something that we heard, which I feel like we've pretty comprehensively covered topics, and so even in nobody said exactly your position, my guess is somebody said something related to it and you can make your case that whatever it is that you feel is important was based on recommendation.

The other thing I just want to be realistic about is that I think you're right, Cassie, who was here went through -- this was not an open forum for everyone in the community who was impacted to come to these hearings and to testify. It was a very controlled testimony environment. And so -- which I think was fine. I think that sort of different commissioners weighed in with different areas that they wanted to learn more about or they thought we should all get on the same page about, but, for example, if you look at how much testimony we heard from the people who actually are most impacted, families and young people, foster families, it was the smallest amount of testimony.

The majority of testimony that we heard were from people who are paid in the field, which their testimony is incredibly important, but -- or if you look at how much judicial input came in, so I just think that I don't want to deceive ourselves by thinking that we had a very representative sort of group of people who had all of the answers come. And yes, we don't have the answers ourselves, however, what we heard was sort of just different experts on different topics come in. We didn't hear from all of the experts and we didn't hear all of the

expert's different opinions. But I think we did pretty good given the amount of hearings that we had and the amount of topics we had to cover, and I think it's important to be clear about what the process is moving forward, how we're going to actually develop the recommendations, but I would rather do that and get to the recommendations than spend a lot of time debating about something that I'm not sure is an issue yet.

**CHAIRMAN SANDERS:** Commissioner Rubin.

**COMMISSIONER RUBIN:** I wanted to talk about Commissioner Zimmerman, because I do agree mostly. I think that -- the prison that I think we moved into, and I think you were saying this and correct me if I'm wrong -- is that upon these recommendations there, and I started to talk about this last time, there is a frame of, what do we feel as a commission we can be prescriptive about, because the evidence we believe pointed to that, and then is it federal legislation, is it regulatory, so we have to interpret and think from an actual perspective collectively and then that's when we're really going to call on Cassie because she's been up on the hill. And so collectively what's prescriptive, what's regulatory, what's legislative, what's state versus federal. And so there is going to be an interpretive moment, but it's how you take those recommendations and that menu and really start to organize it around action, right. And that's where I think we're going to have to make very subjective decisions because that's what we were hired for our experience in.

**CHAIRMAN SANDERS:** So let me just add a couple of things. I think, first of all, we have a document in here of the overview of emerging themes and recommendations that we've had conversations about. And I think while we didn't vote it on, it seemed like there was general consensus on these themes. I think the themes came from the conversations that we've had over the last year and a half. I don't think there was tremendous debate about whether we heard them or didn't hear them. And we had talked about the idea that the recommendations would all fall under themes. And so, it seems that we have a framework that already builds on what we've learned. It's not like we're starting that conversation today.

Part of the idea is to continue to develop the themes that we believe in and it's clear that we need to identify the one or two themes from the conversation we had last week versus having, I think, people called it a Christmas tree. I tend to agree with Jennifer. We are bringing our expertise and there are some people in this room who I think know more about this issue, like Dr. Rubin, than a lot of other people who we've heard. It's important for us to listen to people who have experience as well as the testimony, plus we have a lot of research that didn't come forward in testimony. We have a lot of other people out there who haven't testified that we might read articles from. So I think it's a variety of issues, a variety of sources that are providing this information, but we started the process by the identification of these themes as helping to guide us. Commissioner Zimmerman.

**COMMISSIONER ZIMMERMAN:** This is a question that I probably could ask privately, but for instance, I have limited expertise on tribal sovereignty and limited expertise on federal law and treaties and so I would hope that when we come to that recommendation -- and I'm asking you, can we reach out to who I know are the experts to help frame that narrative, because I can't give you that narrative in a way that could be federally acted upon.

**COMMISSIONER COVINGTON:** As long as it's transparent.

**CHAIRMAN SANDERS:** I think it has to be, but I think then the full commission has the opportunity to decide is that going to be included in the report or not. Ultimately, we will decide once we have a full document whether we're in agreement with that document. Now, my hope is that we vote on a full document and that people can decide whether they agree or disagree with specific recommendations, but that we do first and foremost vote on a full document, but yes, we have to look to experts for some of that because we're not going to have it within our own staff.

**COMMISSIONER COVINGTON:** And we were working on the measures we reached out to others. Some of them have presented testimony, but...

**COMMISSIONER ZIMMERMAN:** I mean for the writing of the actual report, not just testimony, but the language of what needs to be there because the recommendation is to the federal government and it's about honoring a treaty, we have to have that specific language that I have no idea. Do you all have any idea to write that language on the Commission or staff?

**COMMISSIONER DREYFUS:** I think it's about transparency. I think Judge Martin was making a really good point. There should be nothing on a report that we don't transparently validate and every commissioner doesn't have the opportunity to understand, but I don't think the testimony is our only source of recommendation to the Commission. I think I agree with Chairman Sanders, but I do think Judge Martin makes a very good point about the transparency and what is it that sits underneath these recommendations has to be something the Commission agrees is defensible, has some rigger behind it, and if anybody ever questioned our report in the future, that kind of resource is sitting behind our report, right, as to why that recommendation was made. I agree with Commissioner Rodriguez.

**CHAIRMAN SANDERS:** Commissioner Martin. Would there be benefit -- and I ask this to everybody -- but I can try to outline at least my thinking about the process, but I think this going to change with necessity because this isn't a dictatorship. We have to have something that we're duly in agreement with.

**COMMISSIONER MARTIN:** I'm not trying to be difficult and I apologize if I am. I guess that's kind of why I was so anxious to hear what our process was or whether we'd come to some agreement about what our process was. I think we have elementary, maybe we are saying the same thing and I'm not recognizing it, I just don't understand how a recommendation can be made by this commission and as a commissioner, if I have made myself available for all of the meetings and all of the readings, written testimony and verbal testimony and I haven't heard anything said about it how that can end up in our report. I just don't see how that can happen.

Now, you know, I hope -- I want to sign my name to a report that every recommendation we make Pat Martin can go back and be able to identify where that recommendation came from. And I think that's the only way we are then authentic to transparency. I should as a commissioner be able to question the witness, question a written testimony, question a reading that has been offered. And if I can't do that -- and so maybe I'm saying this for naught. Maybe every recommendation will come from and be based on the testimony that we've received, and maybe this is all for naught, but I just want to be clear that we all agree

that we should, if we avail ourselves and come to the meetings and read the readings that we will know where these recommendation are coming from.

**CHAIRMAN SANDERS:** Commissioner Covington.

**COMMISSIONER COVINGTON:** I understand what you're saying, but the Commission as a body, our job is to hear the testimony, to review and read as much as we can to become really knowledgeable, but I think we may still be at a point where we may come up with recommendations that we evolved out of the knowledge of the body of knowledge that aren't written down somewhere but they are a recommendation we created based on what we have in front of us, but that doesn't mean that you could sit there and say, oh, I heard that recommendation while I was in Colorado. There may be recommendations we come up with ourselves that grow kind of organically grow out of the knowledge and testimony.

**COMMISSIONER MARTIN:** I don't think that expert one gave recommendation one and that has to be verbatim our recommendation to the President or Congress. I think that expert one's recommendation one serves as a basis for our recommendation. That's all I'm saying.

**COMMISSIONER COVINGTON:** I totally agree with that. I was hearing you say that our recommendations have to be based sort of in a --

**COMMISSIONER MARTIN:** All I was saying about the document before us is that these are the staff summaries of the recommendations, but from this, I won't be able to tell who made a recommendation that served as the basis for the summary. And so when we get to the deliberations about actual recommendations, if someone can tell me, Pat, that prioritizing funding for prevention in Family Court came from Steve Rubin's recommendation on xyz data, I'm cool. So long as I can go back to the testimony and the review that.

**CHAIRMAN SANDERS:** Let me get to an example. In the theme document, we said former Secretary Condi was here last week, I think everybody agrees with that. I'm not sure at this point that we have directed it back to somebody who testified, but we can certainly say that these are some of the recommendations that came from people that fall under that theme, which might address what you're raising.

**COMMISSIONER PETIT:** I also think that rules of evidence that apply in a courtroom don't apply to a commission. And I think that we have more latitude in terms of where we're taking information from and putting it on the table. For example, we have seen hundreds, if not thousands, of articles in the year and a half from newspapers documenting what's going on in their states. We have not been processing that information on the table. Some people are reading it; some people are not. Similarly, the budgets in the state. There's a huge issue there in terms of what kind of financial recommendations we're going to make, if any, on this thing. That's going to be drawn from different places that we haven't yet had a conversation about. At some point, we can document or we can identify what inspired or informed something and then decide is it something that I agree with or not even if I was privy or part of the analysis or research on it. And that's one of the reasons I thought we divided up responsibility among different subgroups.

**COMMISSIONER RUBIN:** I think that this idea of -- because part of this is setting up the stage of what are our meetings in the fall and I do think that we're compiling all the written and

oral testimony, what were the recommendations that people made. Some of that is actually intermixed with themes and recommendations, right. And so it's more about, if you were to hear a full listing of all the recommendations, then we have to vet, are we missing something that, you know, we're still waiting to get our recommendations about CMS. We are like stuck in the sand because of this monolith that we're waiting and we talked today about contacting several folks in the New York State Medicaid program or folks who have a little bit more direct knowledge. So we're going to be doing a lot of scrambling here in the fall to try to make sure we see testimony, ever hole that we just -- because of the wide range of things we haven't been able to cover, so if we can get that before the next meeting and really -- or somehow figure out how we're going to identify those holes and that's a subsequent meeting where that all comes in when we fully deliberate and continue to work along. I can see from that a process.

**COMMISSIONER BEVAN:** I just want to say thank you to the whole commission. I feel like I didn't say it.

**COMMISSIONER RUBIN:** At that point we then schedule a meeting by November 1st and if people don't agree with us, we tell them the meeting is on October 31st.

**COMMISSIONER MARTIN:** Just so everyone is clear, I have never said that the staff didn't do a good job. I believe the staff has worked very diligently. It's just how we utilize the staff's work. That's all I'm saying.

**COMMISSIONER BEVAN:** I didn't say Teri and David didn't do a good job, I just said it wasn't known to me.

**COMMISSIONER RUBIN:** We'll get that to you.

**CHAIRMAN SANDERS:** So I've heard everyone saying all of us could benefit from a good night's sleep as we go into tomorrow morning. We will reconvene then.

(Proceedings concluded at 5:30 p.m.)

**MEETING ADJOURNED**

## DAY TWO—AUGUST 7, 2015

### Presenters:

- Mark Thomas, Ph.D., Senior Principal, Center for Transforming Health, The MITRE Corporation
- Edward B. Walsh, III, Associate Department Head, Aviation Safety Analysis, The MITRE Corporation

**CHAIRMAN SANDERS:** Good morning, we're going to get started. Welcome to the second day of the Commission to Eliminate Child Abuse and Neglect Fatalities hearing in New York. And we had a full day yesterday and we'll be primarily engaged in deliberations today.

And our first presentation is from Mark Thomas and Edward Walsh from MITRE Corporation. And several of us had the opportunity to visit the MITRE Corporation. And we heard yesterday considerable work and emerging work in New York City about predictive analytics. It's one of the themes that was mentioned in the list of recommendations that we've had from those who've testified in front of the commission. And the -- we heard one of the communities that had been quite successful at reducing fatalities, Hillsborough County, has used predictive analytics to accomplish some of their goals related to reducing child abuse and neglect fatalities.

The opportunity that we had at MITRE was to see advanced work in patient health, in healthcare, as well as airline safety. And it was really quite an eye-opener as to what's possible. And we wanted to make sure that the full commission had the community to hear some of the work being done in other fields so that we can consider what should be applied in child protection.

And before closing, I would just note, if I remember correctly from Mr. Walsh, that the fatalities in the airline industry peaked at around six hundred in the mid-90s and they're consistently at zero now using data in this way and beginning to think differently about quality assurance and the safety culture and we can achieve the same goals in child protection.

So I turn it over to Dr. Mark Thomas and Edward Walsh.

**DR. THOMAS:** Good morning, Commissioner Sanders. Thank you for the opportunity to speak with you this morning and share our thoughts with you on how advances in aviation and patient safety might serve as a model for you to consider as you devise strategies to eliminate child abuse and neglect fatalities.

My name is Dr. Mark Thomas. I'm a senior principal in the Center for Transforming Health with the MITRE Corporation and I'm joined by Ed Walsh who will also be addressing you this morning and will introduce himself in a moment.

However, before we begin, I want to highlight the fact that the views we will share with you this morning are and ours alone. They do not represent the views of any of the government agencies that sponsor our work nor do we imply their endorsement.

To frame our remarks today, I first wanted to provide you with a brief overview of the organization that I represent and the work that we do so that you might have a better context for the information that we'll be sharing. We'll then discuss our work in aviation and patient safety concluding with some thoughts on how these advances might merit further examination as a tool for helping to eliminate child abuse and neglect fatalities.

As we share with you our work in aviation and patient safety, I'd like to draw your attention to a few key themes that I hope are highlighted during our presentation.

First, we understand that eliminating child abuse and neglect fatalities is a very difficult challenge. And frankly, in addition to wanting to do our part to help protect all vulnerable children, the complexity of the problem is one of the key reasons we were interested in examining it.

Second, similar to our work in aviation and patient safety, we believe there is potential to bring together a diverse group of stakeholders under public/private partnership to produce solutions to child abuse and neglect fatalities.

And third, we believe it is possible to leverage the passion of the stakeholders in the child welfare community along with data and technology to make a difference.

Ed and I are here this morning as representatives of the MITRE Corporation founded in 1958 to work in the public interest. MITRE is an independent not-for-profit organization that operates research and development centers for the federal government. Our mission is to apply -- is to advance and apply science, technology, systems engineering, and strategy to enable the government and the private sector to make better decisions and implement solutions to complex challenges of global and national significance. My primary role and responsibility at MITRE is to leverage the organization's unique capabilities and expertise to help develop solutions to the complex problems facing the Department of Health and Human Services and the citizens that they serve.

Since MITRE's sole purpose is to operate federally-funded research and development centers for FFRDCs, I wanted to take a brief moment to describe them to you.

FFRDCs are government created and sponsored organizations that exist to help government address complex problems that require a high degree of objectivity and without any conflicts of interest. We operate as long-term strategic partners to our sponsoring government agencies. Federal law and regulations allow FFRDCs to have access to sensitive information that would not be shared with other types of organizations.

In the orange box on this slide, you'll notice that the special role that FFRDCs are to play is articulated in the Federal Acquisition Regulation or the FAR. I also wanted to call your attention to the second bullet on this slide.

As the operator of FFRDCs, a large portion of our research occurs within our independent research and development program. When MITRE was incorporated more than fifty years ago,

the founders recognized the value of research that was separate from but aligned with the direct work for our sponsors. This separation enables us to look into the future and take calculated risks. For example, our researchers are encouraged to identify possibly disruptive technologies and start exploring solutions to problems that are not yet well defined. We strive to see sponsors' challenges in fundamentally new ways that inspire innovative and sometimes revolutionary solutions. It is under this internal research and development program that we have started to examine the problem of child abuse and neglect fatalities. While it is still in the early stages of our examination, we've begun to explore the utility of our work in aviation and patient safety as a model to address this problem. Under our internal research and development program, we are just now beginning to partner with the Health and Human Service Agency at the County of San Diego to test this concept further.

I'll now turn the time to my capable colleague Ed Walsh who will describe our work in aviation safety.

**EDWARD WALSH:** Thank you, Mark, for the kind introduction.

My name is Ed Walsh and I am the associate department head at MITRE for aviation safety analysis. I am here today to speak about my experience with the public/private partnership that MITRE has supported since October, 2007 to improve aviation safety, which I will refer to simply as the partnership for this talk.

Commercial aviation in the United States is currently enjoying a golden age of safety. Since 2007, there have been only two fatal accidents operated by U.S. commercial air carriers on domestic soil. The volume of air traffic is projected to increase in the coming years, and new technologies are being introduced to replace antiquated ones as part of the next generation air transportation system. Given these changes, the public/private partnership was created in an effort to maintain and improve on the high level of safety in the system.

The public/private partnership for aviation safety was created in October, 2007 and is a true collaboration including government and the aviation industry. Its mission is to facilitate the sharing of aviation safety data to conduct predictive analysis, identify emerging risk and systemic vulnerabilities before the next accident or serious incident occurs. Achieving this mission will ultimately lead to the creation of mitigation strategies to eliminate the identified risks from the system and prevent the occurrence of fatal accidents.

This partnership initially started with seven airlines in 2007 and has since grown to include forty-five to encompass over ninety-nine percent of the U.S. commercial operations. Other key members of the aviation industry are represented including fourteen general aviation members, eleven industry manufacturer, trade, and labor organizations, five government agencies, two maintenance, repair, and overhaul, one academic, and MITRE. All of the stakeholder groups listed here are actively engaged in the partnership. Decision-making is collaborative in nature with a decision by consensus governance model in place.

While the program is entirely funded by the government, industry groups have equal say in developing priorities and policy for the partnership. Data contributions for us within the partnership are entirely voluntary, meaning that there is no formal mandate for participation. All of the studies and analysis conducted for the partnership are based on aggregated information with the mission of identifying emerging systemic risks and systemic

vulnerabilities. All of the studies conducted by this partnership are entirely safety-focused. The partnership governance prevents a study from being conducted that does not directly tie back to safety.

Because of concerns about data protection, MITRE was asked to serve as a trusted third party for the public/private partnership. As a private not-for-profit company chartered to work in the public interest, MITRE enters into cooperative agreements with data providers to collect, aggregate, store, process, and analyze safety data for the partnership while ensuring protection from release to the public under, for example, the Freedom of Information Act. To that end, MITRE collects, stores, and aggregates vast amounts of safety data from many of the partnership stakeholders. MITRE also conducts statistical analysis, performs data mining and natural language processing and fuses multiple data sources together to satisfy analysis requirements for the partnership. MITRE shares the results via a secure Internet portal and facilitates collaboration for the stakeholder community.

So what sort of data is used within the partnership to advance aviation safety? The first two data sources here are proprietary sensitive data collected by the airline industry and shared with the partnership. Airline safety reports are collected as part of voluntary non-punitive anonymous reporting programs. Any time a pilot, maintenance technician, dispatcher, or even an in-flight cabin crew member witnesses or observes an event that compromises safety of the operation in some way, shape, or form, they can write a narrative description of the event in a safety report.

The aviation safety public/private partnership currently has a database of two hundred thirty-three thousands of these reports available for analysis from over fifty operators.

As part of establishing trust with the community, the partnership's governance requires that these data be de-identified, meaning the aircraft call sign and tail number are wiped and the date of the month is reset to the first, though the month and year are retained for trending analysis.

One specific challenge in working with this data centers around the issue of standardization. There is no industry-accepted standard taxonomy for these data. As a result, the partnership developed a complex extract, transform, and load or ETL process to convert the data from the native airline format to a unified format for use within the bounds of the partnership. Additionally, each operator classifies safety events according to their internal identification criteria. Subsequently, after completing the ETL process, the partnership developed and routinely runs a series of natural language processing algorithms to associate the safety reports with consensus definitions for known safety concepts and to detect emerging safety issues and threats reported in the safety reporting data.

Digital aircraft data can be thought of as being similar in nature to aircraft black box data. Sensors onboard the aircraft capture quantitative measures such as airspeed, rate of descent, and aircraft configuration. From this data, the partnership calculates and reports on trends or events that are used to assess and mitigate safety risks. These data are also de-identified as I previously discussed for the safety reporting data. These two data tests are critical but they are not the only data sources that are available for analysis.

Another reason the government asks MITRE to serve as a trusted data steward is due to the broad access to government and public data sources that can be brought to bear for the benefit of the partnership. For example, MITRE has access to ninety-five million radar surveillance flights which capture position, speed, and altitude reports for almost all aircraft operating in U.S. air space. MITRE also has access to seventy-seven thousand five hundred ATC safety reports which is a voluntary non-punitive anonymous reporting program for air traffic control.

Finally, MITRE brings multiple weather and infrastructure data sets to the table which provides a full contextual information for safety events derived from these data.

With all this data available for use by the partnership, what types of metrics analysis are possible?

Known precursor events to previous fatal accidents can be measured and trended through analysis of data. For example, the partnership is able to identify from the data the frequency of terrain proximity events, instances where aircraft are not at the proper assigned altitude, speed, or course thereby leading to a miss-crossing restriction, and close proximity events, among many others.

Using these analysis results, the partnership conducts many different types of analytical studies for the different mission areas of the partnership. These include safety enhancement assessments whereby previously implemented risk mitigation strategies are measured to ensure they are working as they were intended to and if the risk in the system is decreasing as a result of the implementation benchmarking where individual operators are able to compare their individual performance in the safety risk area to the rest of the industry. The operator has always been able to quantify their own rate of occurrence in these areas but through this partnership they are able compare their performance to their peers and know definitively if an event rate is good or bad.

Directive studies which are deep dives into a single safety topic, a joint government and industry working group forms when a topic is identified and can spend as much as one year identifying what the risk associated with the safety concept is, where the events are occurring, and most importantly why they are occurring. Known risk monitoring are a series of metrics associated with known systemic risk areas monitored by the joint government and industry working group to detect any changes to the system. Are these events occurring at new locations? Is the rate of occurrence increasing unexpectedly? All of these types of studies generally result in one or more interactive dashboards to present the results to the community. These dashboards are hosted on a secure Web portal on the Internet. The portal serves as a secure gateway for the exchange of aviation safety information by providing access to safety reports based on aggregated de-identified analysis of data, access to peers within the aviation safety community, and access to detailed safety analysis of public operational data. The dashboards hosted on the portal are not static. By their very design they are interactive in nature providing the community with a high level of customization.

As I previously mentioned, there is a lack of standardization in the aviation safety domain. One airline's definition for a safety event almost certainly will differ from another's. Further, the types of questions that one operator may ask will differ from another for a variety of

reasons, such as internal training priorities or location-specific queries due to the hub and spoke nature of the system.

One specific example of a recent study conducted by the aviation safety public/private partnership focused on aircraft not properly configured for takeoff with an emphasis on flap configuration. Typically an aircraft will extend its flaps prior to takeoff to aid the wing in generating lift. If the flaps are not extended properly, the wing's ability to produce lift is reduced which can create problems for an aircraft attempting to take off. The study found that, though rare, these events do occur systemically. As a direct result of the completed study, a safety alert for operators or SAFO was published to raise awareness of the risk and intervening factors identified in the study. As was the case with the misconfiguration study results, information contained in a SAFO is often time critical and they are an important information tool that alerts, educates, and makes recommendations to the aviation community.

What are some of the key lessons learned from the aviation safety public/private partnership? First, establishing a collaborative governance model which includes joint government and industry decision-making. Compromises are needed along the way due to the sensitive nature of the data and the results that are generated. Developing trust among all parties is critical to the success of the program. To build that trust, everything that the partnership does must be completely transparent to all players. Another tenet of developing trust is to respect data ownership. MITRE was asked to serve in the role of the data steward and makes no claim of ownership of the data shared with the partnership. To retain trust, it is critical to be responsive to the needs of the data provider to ensure their continued participation in the program. The data must be completely safeguarded. Any inadvertent leakage or mistreatment of the data could have serious negative repercussions for the partnership. And once again, I can't emphasize enough how critical it is to maintain trust with the community. Data stewardship means taking great care with data management practices to ensure proper use and protection of all data shared with the partnership.

And finally, the partnership must provide valuable insights that could not have been known through an individual's analysis of their data alone. Only when the data are collected and aggregated are emerging systemic risks apparent that will lead to timely mitigation.

This concludes my prepared statement. I will now turn the floor back over to Mark to speak about patient safety and how this model can apply to child safety.

Thank you for your time.

**DR. THOMAS:** Thank you, Ed.

Now that we've discussed our work in aviation safety, I'd like to talk briefly about how we've built upon the model, technologies, and tools developed for aviation safety and apply them in another area of importance: Patient safety.

In the United States, medical errors result in ninety-eight thousand patient deaths and one hundred eighty-one thousand injuries each year. Because of the significance of this problem, MITRE has sponsored a patient safety initiative to explore how having access to improved

insights will enable hospitals to reduce this significant number of preventable deaths and injuries.

As you can see here, building upon the same approach described in our aviation safety work, MITRE established a public/private partnership with three leading pediatric hospitals to facilitate engagement and action. The partners listed here voluntarily partner with each other and MITRE to create new insights and interventions in health safety. The focus is not on what is already known or on measuring compliance with already-established best practices but to generate new knowledge about those factors impacting patient safety that has yet to be identified by patient safety researchers. Like those who have partnered to improve aviation safety, these health systems understand that they will learn more from analyzing their data in the aggregate with each other than they will be able to deduce by examining their data alone. For example, aggregated data and analytics allows the partners to develop benchmarks and measure their performance against the average of the group. The MITRE-operated public/private partnership also allows the hospitals to share sensitive data with MITRE for the purposes of analysis but to keep this information confidential and safeguarded from the other partners. Similar to the goals of this commission, the patient safety partnership is focused on understanding what factors are at the root of preventable death and injuries.

Like our work in aviation, our patient safety work also benefits from bringing together diverse types of data that have not heretofore been analyzed together. This approach is central to our ability generate new insights and to develop predictive models and practical approaches to safety problems. This enables our partners to address the root causes of safety problems before they result in injury or death. It is also important to note that the partner hospitals do not have to clean their data or provide it in a standardized format to MITRE before it is able to be ingested and analyzed. To reduce barriers to voluntary participation, MITRE takes the data in the state that it is in and undertakes the cleaning and preparation necessary to integrate and analyze the data. Similar to aviation, the types and amounts of data that we gather for patient safety goes far beyond what is traditionally reported to the government or other regulators.

This slide depicts the safety analytics dashboard that our hospital partners use to visualize and interact with their data. They are not only able to see how they are performing within their hospital but are able to compare the performance against the average performance of the group. They are also able to drill down into each of these measures and examine the data reflected therein. Of great importance on the right-hand side of the dashboard you'll see that the hospitals can filter their data and impose benchmarks or thresholds of their own design. This allows them to not only see their performance on standardized measures but allows them to customize those measures to meet their own definitions and needs.

As I conclude my description of our patient safety work, I want to emphasize what while both of these aviation and patient safety systems allow for an in-depth examination of individual cases, there is tremendous value in the ability to conduct systemic analyses, which create opportunity for risk and identification and remediation that will benefit many.

I also want to emphasize that both these systems were designed to find the needle in the haystack. They ingest millions of data points, tens of millions of data points to proactively

identify and create the opportunity to mitigate a trajectory that would otherwise end in catastrophe for a comparatively small number of people.

Having now covered our work in aviation and patient safety, I'd now like to share some thoughts for you to consider on how these solutions might also merit consideration in addressing child abuse and neglect fatalities.

As we've described the public/private partnerships, there are three common building blocks for their success and are at the core of the reason why stakeholders are willing to participate voluntarily. Should a similar approach be undertaken to address child abuse and neglect fatalities, these building blocks ought to be considered. Developing trusted relationships among stakeholders would be key and the governance of the partnership should be designed in a way that reinforces that trust.

Stakeholders must see real value or benefit there for participation. This value is largely created through aggregated data and access to analytic tools and measures that help them achieve their objectives in a way that they would not be able to do on their own. Since MITRE is an independent not-for-profit organization that operates federally-funded research and development centers, we are able to receive data from both government agencies and from private organizations that would not want to share their data directly with other stakeholders or the government. We also then provide the neutral or safe environment and the analytic tools to the stakeholders and conduct research and analysis as directed.

As we have initially begun to look at some of the barriers to actionable information for eliminating child abuse and neglect fatalities, we are seeing challenges that appear very similar to those we initially encountered in our aviation and patient safety work. Data related to a fatality is heterogeneous and complex. Sometimes the findings that are identified may not be generalizable to other situations or may rely on limited data. Data is often of poor quality and may not be easy to integrate with other data or be easily accessible. These data problems then in turn create challenges to the development of evidence-based measures or interventions. This then creates challenges for those on the front lines in the child welfare system who likely struggle with trying to make easy and informed use of the data that is available. These factors ultimately hinder the ability to identify true risks and respond proactively.

Because of the similarities between these challenges and those faced by the stakeholders in the public/private partnership in aviation and patient safety and because our mission drives us to look for significant national challenges, we've begun to think about what an analytics-focused public/private partnership for eliminating child abuse and neglect fatalities would look like.

This slide attempts to capture what this partnership could entail. Similar to our other public/private partnerships, this partnership could potentially focus on bringing together the right set of stakeholders to work on the problem. This would conceivably include federal, state, and local governments and their counterparts in the private industry and/or advocacy organizations or other non-governmental organizations. These stakeholders could then establish a governance structure that would enable that the aggregation of related data likely coming from various sources both inside and outside of the child welfare system. Non-child

welfare sources of data could conceivably include electronic health records, information from law enforcement, schools, and others.

As the data is aggregated, the partnership could prioritize the types of risk modeling, visualization tools, and reporting they believe would be of most use. The partnership could also direct specific research studies on critical topics that could then inform policy and decision-making. Please note that the aggregation of this data allows for the creation of a picture that the government or any single child welfare agency would otherwise never see.

As the partnership matures, it may be able to generate new insights that allow for proactive intervention and provide a basis from which scarce or limited resources can target the highest priority needs. The hope is that this would then create an environment where the elimination of child abuse and neglected fatalities becomes possible.

As I conclude, let me reiterate that first we understand that eliminating child abuse and neglect is a very difficult challenge but that it bears characteristics similar to the challenges we have addressed in aviation and patient safety.

Second, similar to our work in aviation and patient safety, we believe there is potential to bring together a diverse group of stakeholders under a public/private partnership to pursue solutions to this complex challenge.

And lastly, we believe that it is possible to leverage the passion of the stakeholders in the child welfare communities along with data and technology to make a difference.

Thank you very much for the opportunity to share our thoughts with you this morning. This concludes our prepared remarks.

**CHAIRMAN SANDERS:** Thank you. I see there are a couple of questions.

Actually, I'd like to start with a question.

One of the things that seems really intriguing is the work where the pilots or others provide information about things that could have been -- could have created a disaster. And so thinking about that in child welfare, a child protection worker identifies that they didn't have time to go out to see a child or something along those lines.

How do you consider that kind of information within all of the other data? Just how do you approach it in determining where some of the trends might be?

**DR. THOMAS:** Do you want to speak specifically to the aviation, how do you incorporate air traffic control or the unstructured data into the analysis?

**EDWARD WALSH:** So I talked a bit about the safety reporting data that we receive. I mentioned that we have an ETL process in place. We have a very low barrier to entry, as Mark was discussing, where we take the data in whatever form it resides it at the operated and ingest it and convert it to a standardized form that we use for analysis.

We have developed a number of national language processing routines to go in and identify all the reports associated with a safety concept or an event based off of a set of identification criteria. Because there is no standard definition across the industry, one airline's definition

for a type of event or incident is going to differ from another one, so we have to go in and look at the language, the words that the reporter was using to associate that report with that safety event. Once we have identified all of the reports, that's when we go in and do our analysis of the contributing factors that are being reported by the pilot or by the dispatcher, whoever, looking at the words that they're using in the narrative description of the event itself.

**CHAIRMAN SANDERS:** So you can tell then whether those events are increasing or decreasing and that's the kind of information that can be used by somebody to help to improve safety; is that --

**EDWARD WALSH:** Yes, that's exactly right.

**CHAIRMAN SANDERS:** Commissioner Cramer?

**COMMISSIONER CRAMER:** Thank you, Mr. Chairman. Could you discuss some of the costs in your aviation safety center? Where does your funding come from? How much does that cost?

**EDWARD WALSH:** So the cost to participate for the individual participants, data providers is nil. The government assumes all of the costs and the responsibility for initially standing up and now continued operation of the partnership.

**COMMISSIONER CRAMER:** What is that cost?

**EDWARD WALSH:** So --

**COMMISSIONER CRAMER:** You've existed since 2007.

**EDWARD WALSH:** 2007, yes.

**COMMISSIONER CRAMER:** All right. Could you give me some --

**EDWARD WALSH:** It's about -- let's see. I would say it's about thirteen million a year.

**COMMISSIONER CRAMER:** A year? And where does that funding come from?

**EDWARD WALSH:** It comes from the federal government.

**COMMISSIONER CRAMER:** What budget?

**EDWARD WALSH:** So it's spread out across of the couple of different -- of the budgets. We have a line item in the congressional budget that funds a part of the partnership. We also have additional industrial funding sources as well.

**COMMISSIONER CRAMER:** Does that line item come from aviation money or --

**EDWARD WALSH:** It's part of the line item in the congressional budget for the --

**COMMISSIONER CRAMER:** Strictly for this project, this named project?

**EDWARD WALSH:** Yes.

**COMMISSIONER CRAMER:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Bevan?

**COMMISSIONER BEVAN:** So is this money is appropriated every year? Is this something that you worry about every year, was it a line item that you can rely on?

**EDWARD WALSH:** Yes.

**COMMISSIONER CRAMER:** That's hard to imagine.

**COMMISSIONER BEVAN:** My question -- I just love that slide you have on the child welfare, on how you could use your framework to plug in child welfare and the fact that you're talking about aggregated data and that can provide a picture for us of the child fatalities and then you could also -- like we could plug in like high risk factors and then you could help us with identifying, you know, what's a likely event because you said you could almost -- you could generate knowledge about the highest need or the highest risk and then address it.

Can you just tell us a little more about that for child welfare?

**DR. THOMAS:** Absolutely.

Again, it's our concept for how this could occur building on these same models but similar to the work in patient safety and aviation safety. That similar approach is sort of the standard approach, helping them identify where areas of risk, you know, exist and understand what sort of, you know, limited resources can and should be brought to bear to address those risks.

**COMMISSIONER BEVAN:** How much of an increase would you need from the thirteen million to do the child neglect or child -- the work we're talking about? How much more?

**DR. THOMAS:** While I'd love to be able to give you that exact number, I'm not prepared to do so. I'm sure that it would be less than what is needed to do the aviation safety work given that you've got so many more stakeholders at the state and local levels, so you can consider that in the two examples we've shared with you it's, relatively speaking, a small number of organizations. Even though it's a comprehensive group of organizations, it's a small number of organizations. So if you're looking at bringing data from states or other organizations, you need to account for those costs as well.

**COMMISSIONER BEVAN:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Dreyfus?

**COMMISSIONER DREYFUS:** Thank you. It's nice to see you guys again. I really enjoyed our time when we were with you.

So I have a couple of questions.

I know back when I was a child welfare director and the worst days would happen when a child would die and they were known to us in the child protective system. Over years I truly did start seeing recurring themes, recurring factors in those cases that, you know, we would be reviewing. But I also always thought about those kids -- and I do believe that what you're talking about could work in those instances.

But I also sit up here over this past year and a half and I'm thinking about all these kids twofold: One is that should have been known to our system and weren't; what was going on that didn't have people let us know about kids at significant risk, right, and harm that should

have been known. That's why I always worry when we say, well, they're not in system like they've fallen into this invisible pot when I keep thinking well, why weren't they known to our system. That's one question is like how far can this data go to start getting at root causes to go beyond just trying to prevent the death of a child? Because when a child's at real risk of being killed, yes, we might keep that death from happening, and I hope we do, but a whole lot of harm has happened to them along the way up to that point that has dramatically harmed the trajectory of their lives.

So I guess I'm asking the question -- I really do believe that we could use this approach for kids in the system, the factors that we know are prevalent, and putting in place the kinds of protocols and processes cross partners, right, that would keep kids in the system from being killed. I get that. But I'm trying to think about those kids not known to the system, why weren't they, and how do we not wait until we're at the moment before that child's at serious risk of being killed to keep this horrible developmental trajectory that goes up that's happening long before that actual event occurs.

So I'm just trying to understand how far back does this -- have the opportunity over time - - I know it's not immediate but over time to take us?

**DR. THOMAS:** Well, to be clear, we won't know until we look, right, until we are able to have the data accessible to do those types of, you know, analyses. However, the concept that we are suggesting for your consideration that mirrors what we've done in aviation and patient safety is that it's not just relying upon data that currently exists within the child welfare system but you're looking to other sources of data that could be integrated.

An anecdote that had been shared with me as an example is a child that was, you know, a near fatality situation when someone was released from prison and able to return home to a place where there was a restraining order in place. Because the right hand and the left hand wasn't aware of that situation, this individual's allowed to go back and perpetrate the abuse which resulted in the near fatality. So it could be something as simple, if you will, integrating information from the courts and the criminal justice system so we have a more complete picture of what's going on. But I believe that there may be other opportunities as well for additional data maybe coming in from your emergency medical system, you know, Medicaid. If the child isn't current on their well child visits or, you know, regular preventative care, perhaps that's another signal.

So it gets back to the point of bringing together types of data that have never been brought together before and never been analyzed together to look to see if there might be a signal in those other data that might help you get upstream from those children who aren't on our radar screen as yet.

**COMMISSIONER DREYFUS:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Martin?

**COMMISSIONER MARTIN:** Good morning, gentleman. Thank you very much. So I will confess up front, I am a real visual person so if I don't really see it, it's hard for me to understand.

I appreciate the slides you presented to us and how you're looking at this project from our perspective from eliminating these neglect fatalities.

If I understand the basic concept -- and I'm excited about looking at this.

If I understand the basic concept, what you do is you take a lot of data from a lot of different data points, you put it in a crystal ball, and then you come out and help analyze that data so that we can now look at certain decision points, if you will, and determine how we can reduce risk and make it safer, if I understand the general concept.

To me, as a non, you know, analytical person, that means that the base of and how well we can do is based on the data we can give you. And one of my concerns is that the data that we have available to us today is not all that great. I mean, I think that's one of our major problems. The main data sources that we're utilizing now to count the number of fatalities that we have or near fatalities isn't really reliable and we all, every one of us knows that there's problems with that data and accuracy. We have different views about how bad that data is but we all determined that the data is bad. To the extent that we have some communities that aren't providing any data. So Native American communities really aren't providing any data in any kind of central place, whether it's with their tribes or with the federal government.

So how would we loop in those communities, Native American communities, and how would we give you better data if we're starting from a point where we don't -- how can you help us if we don't have good data to give you?

**DR. THOMAS:** So I'll share a thought, and Ed may have perspectives from the aviation partnership that they've developed.

But the three, you know, foundational blocks that I mentioned a few slides back about value that people derive, again the partnerships we've described are voluntary in nature but the reason why people are willing to participate is because they are able to get something positive out of that interaction they wouldn't be able to get otherwise. I would assume those communities you mentioned are as interested in anyone else as preventing these types of tragedies. It sounds like the system is such that right now there may not be an incentive to improve the data that they do have or to report more regularly or to improve the quality of the data because the return on that investment of that effort isn't necessarily there for that. The idea of the partnership here is that there's value in improving your data and bringing it forward.

And then the last thought that comes to mind is that there's value, I believe, in triangulating between data sources. So there may be some child welfare data of moderate or poor quality but there may be other sources of data that can be brought to bear. So perhaps it's looking at the Medicaid population in a given community as another source of data or information from schools or from the juvenile justice system or the like.

**COMMISSIONER MARTIN:** So bringing in different sources to improve the ultimate data that you're given?

**DR. THOMAS:** Correct. And I believe there's sort of a virtuous cycle that could exist there. They can reinforce one another to improve quality. Because bringing together this type of environment you're able to see where your data quality problems are at and highlight them

and determine what sort of investment might be worthwhile to improve that data and understand why having that data improved would improve your outcomes.

**EDWARD WALSH:** And if I might add to your point about participation in the program, I mentioned back in 2007 we had seven airlines in aviation safety that were participating in the partnership. It wasn't just the case that we went from seven to forty-five overnight. It was a gradual growth. We had to continually demonstrate the trust, value, and analytics within the partnership. And we would say complete a study using the data from the participants at the time and then we would get outreach and we would get maybe another two or three airlines to sign up. And then we would do it again, continuing outreach, we'd get another two or three airlines to sign up. It was a very gradual growth process. It wasn't something that happened overnight.

**COMMISSIONER MARTIN:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Rubin?

**COMMISSIONER RUBIN:** Someone who spends a lot time thinking about data myself in terms of data analytics and thinking about this space of predictive analytics and I believe there is a role for it.

Just to let you know, I actually have a lot of skepticism and whether it's the aviation example or the hospital example, what you're really trying to do is standardize events around episodes. In this case, the list of threats to this model working in child welfare in a systematic way are numerous and makes we wonder whether, to some degree, this vision is not practical, that the obstacles are insurmountable in many ways.

So if I walk through, for example, first of all, I mean, I think that the idea that when you're looking at a central line and a central line infection or a safety event on an airplane, I know there are humans involved but now you're talking about whether you can adequately predict whether mom who was high this morning is going to kill the baby; right? These are people, these are complex emotions and family systems. And I still haven't made that leap that we can systematically do that even if we had all the data. And then when we get to the quality of the data is the idea that, you know, there's so many other unmeasured factors. And certainly if you were in a system that shares all of their data you still don't know if a new boyfriend came into the house last night; right? And so the question of the percent of the variation that would be explained even if you had all the data would be sufficient enough to actually prevent a lot of the events. And I think of this in the context of John Mattingly. I mean, this is where if John had started right before this, think about how complex and challenging these systems are and how they're locally favored; how a sort of standardized model could just be inserted in that to change all those threats and challenges that occur in New York City every day.

And then there's issues of data sharing. Like, you know, what I saw was we could potentially create this national model when I still think of it are you guys more of a vendor for an individual city maybe further along and that the dream of having multiple cities all aligned on the same system is just not practical because it's all about local MOUs, it's all about the quality of the data, the way they structure -- some systems have their own Medicaid programs

for kids in foster care, some don't, and so there are two different city to city that this may be sort of an offer for the predictive analytics base for the city that's ready for it.

And then -- so all those things kind of come up in my mind and say, well, you're only as good as the data that goes in. And so try to assuage me if you can but, you know, is child welfare just too different in which case we can't replicate an aviation model? And so that's what I'm struggling with still.

**DR. THOMAS:** Sure. No, those are all great observations and I hope that the takeaway isn't that we believe we have silver bullet to the solution. I think -- I don't want to speculate. I can only say that the challenges that we've observed in our review of the problem bear a lot of similarities to the other challenges that have been faced elsewhere and they have been able to make dramatic improvements. Aviation is certainly an incredible example of where they have eliminated essentially the fatalities to zero. But patient safety, for example, is still a work in progress. There are a lot of, you know, opportunities for improvement there, but they are making dramatic improvements.

So I wouldn't let perfect be the enemy of the good. I think that there is potential here. But you certainly have some very valid points and I wouldn't want to not try rather than not try at all and not know if there might be an opportunity to have an impact.

And then just one last comment. To be clear, we are not a vendor, we are not proposing a commercial or other type of solution, merely putting forward a model where the federally-funded research and development centers earn a position to host a type of model that could start local, could grow nationally, it could be kind of a hub- and-spoke-type model looking, for example, at how different health information exchanges are being set up around country to exchange, electronic health data might be a possibility as well. Again, the concept is merely one we think merits some consideration but certainly with eyes wide open and a lot of, you know, thoughtful consideration.

**CHAIRMAN SANDERS:** Commissioner Petit?

**COMMISSIONER PETIT:** I'm sorry I missed part of your presentation.

The most serious horrific child fatality I ever dealt with had many of the characteristics that we all have identified and Susan, Commissioner Dreyfus, said that after a while you got to see these repeat kind of cases and I'm sure the DA would say he saw the same kind of patterns and behavior. And our governor was very upset by this death and the issue was let's just get rid of -- let's take all the children that in these kind of situations out their households; how many are there. And I said, Governor, we have several thousand children in households like this and by the way, it's been four years since one was killed. So we went four years without any children from that cohort being killed.

It seems to me the challenge, and Commissioner Rubin has spoken to it, is that the dominant authorities in both situations that we care about the most, one is the pilot. We all want a sane mentally well pilot. But the kids live with a parent who is the dominant force in their life and the parents have many of the characteristics.

So I just wondered if what we're talking about is instead of two per hundred thousand kids each year, which is what the fatality rate is, maybe where this has some utility is you can

bring it down to eight thousand children a year or four thousand children a year. Is it possible to bring it down to -- as you said, don't have the best be the enemy of the good on this thing. So is there a way of shrinking all of this in a way that narrows the field even if it doesn't precisely identify individuals? Because it's an active hot button issue with these kids. I mean, they're always in danger when they're living in certain households.

**DR. THOMAS:** So I certainly don't want to speculate on what's possible. I think we see promise in these approaches and I think that, you know, being able to identify the systemic risk is also of also great value. It could maybe help create sort of larger scale impacts on the problems. I don't know if zero is a possibility given the number of factors that are unique to this type of a situation. But I'm thinking about the example that Ed shared around flaps being configured for takeoff. Because of this systemic analysis that was going on, that problem was able to be identified which then led to a change in the way they configured to take off which then reduced that, you know, risk from resulting in a tragedy.

So I think it's important to be aware that it's great that these systems could help you maybe kind drill down into what's going on an individual case but the ability to understand what's happening systemically I would say is equally as valuable and can help perhaps create improvements for a larger swath of the children in the system potentially.

**COMMISSIONER PETIT:** Thank you.

**CHAIRMAN SANDERS:** So I know Commissioner Covington wants to get in. Commissioner Dreyfus I think wanted to respond to Commissioner Rubin, and I may follow up with a response.

**COMMISSIONER DREYFUS:** Thanks. Commissioner Rubin asked you question. So I really do get what you're getting at. And one of the things I thought when I went to MITRE and I saw this, I truly could see this being a significant part of this commission's work. And I don't think it's a panacea, I don't think it's -- you know, this is a complex issue but I could see this kind of analytics operating real time in this country, right, in this child welfare space. But the way I always thought about it, if this was going to -- and again, it would evolve, is I think this would be best if it was done in county- operated states and if it was done -- I'm just going to make up a number -- twenty counties. Because when I worked at the county level, right, our human services agency had all the data, right, they administered all of the social and health service program; they weren't in these boxes and silos.

I think of Uma in Baltimore; right -- not Baltimore, Montgomery -- where she had all of social and health services under her responsibility. I could see there being -- I know you work in San Diego with NIC but I could see a group of counties coming together that do work in these -- not in these silos but really do have this more integrated data available to them right now doing this and in so doing the whole country will benefit. It's not just those fifteen counties or whatever that are going to benefit. The knowledge that's going to be coming out of it -- Michael, it was your vision back in the 90s when you envisioned -- when you were at the Child Welfare League and we were one of the first states, Wisconsin, to jump at it -- when you envisioned a data repository at Chapin Hall. I think this was part of your longer-term vision.

I really do get what you're saying and I don't think this would work from the get-go at a state level initially but I do think a group of counties with integrated social and health services systems really could do this and the knowledge gained we all benefit from.

So I just --

**COMMISSIONER RUBIN:** I agree a lot with what you're saying but I think that the -- where I have seen the value of these models so far, as you were discussing with one of the deputies here in New York, is A, I believe it's locally driven just like you said in terms of who's ready, right, to do this. B, I think it's not - it accepts that we're not predicting -- we're actually trying to figure how to attribute resources as a population segmentation model. And so in limited resources and a workforce that's really pressed and challenged in terms of their skill level, et cetera, how do we ensure when we're going to be multi-disciplinary teams, we can't do it for everyone, but when a case looks like it's about to be at risk we can identify a subset of cases that need to elevate. And so when we at the Tampa experiment or other experiments -- whereas I can't envision a national strategy or repository, I can envision systems that are ready to really think about population management, and they have wide enough data sharing to think about how they can better align their resources. And that's as far as I feel like I can go in this space right now.

**CHAIRMAN SANDERS:** I think, Commissioner Rubin, you make some really great points. I would heckle in part what Susan said and also what you just said.

I think from my experience in Los Angeles, three thousand workers are all making decisions about how they're allocating their time and they make it based on their own personal feeling versus making it on data that's actually been analyzed to say this is where your time -- if you're going to have limited time, this is where it should be devoted. And I think that there's some real promise in rethinking how those decisions are made, which I think is not different than what you're saying but I think that it's -- I think that has tremendous potential. Because given what we have heard, I would rather have a worker spending time with an infant who has a parent who's missed three appointments with a primary care physician than with a seventeen-year-old who is in and out of the house if we're looking specifically at this issue of safety. And I think -- but that's not going to be the decision that she will make because the pressure will be on for her time to be allocated in other places. I think what Tampa did by also adding on the change in supervision, the ability to offer different support, I think with the right information it has tremendous potential.

The other thing, and just quickly to Commissioner Martin's point, if I think about the data again in a place like Los Angeles, probably pretty mediocre. If I were to get something back from the federal government that gave a road map that said here is what -- these are some things you need to consider because the risk here is such that you're going to start seeing this trend of serious injuries to infants go up, you can bet that we would make sure that the quality of data improved because it would be something of value being offered. Right now there's very little that states or counties get back in valuable analysis of the information that's produced monthly, weekly that goes to the federal government. And so I think there are some things that are considerations that we should make about this that have the potential to, as Michael said, maybe not achieve perfection but I think makes some differences.

Commissioner Martin?

**COMMISSIONER MARTIN:** So I don't disagree -- I don't think I disagree with anything that's been said. One of the things you would caution you, and I would ask for your assistance, is making certain -- it seems to me that so much of our research is generated, you know, on certain pockets of our community. So for years our research on juvenile justice was based on what boys were doing and then we tried to take that same set of factors and just plop it on top of girls. And so I don't want us to leave out the fringes of our community.

So picking a jurisdiction, picking five or fifteen counties in which to use to develop this data, I don't have a problem with that but I want to make certain that we do it in a way that does not eliminate the other communities that we know need help.

And so off the top of my head, Native Americans, I think there are vastly different issues going on in Indian territory as opposed to Illinois and Cook County where I am that may, in a fact, contribute to what your analysis may be. Somehow I think if we're going to engage in this kind of commitment and investment we have to figure out how to bring in some of those outlying communities or communities that aren't as prevalent as Cook County, Illinois.

And so that's all I'm saying. I don't disagree but I think we still have to bring in these other communities.

**CHAIRMAN SANDERS:** Commissioner Bevan?

**COMMISSIONER BEVAN:** I think the stakeholder issue is not an easy one but I do think because it's voluntary that Native Americans and others who have come before this commission for a year and a half with everyone -- no one disagrees that we want to decrease child fatalities. There isn't a pocket of opposition. But I think what this approach would help us would be to raise awareness among all these stakeholders and data places that are -- again use of data that we have never put together before. I mean, going beyond child welfare which is also -- all we've said for a year and a half is that that is not just a child welfare issue, it's an issue of lots of other areas, judicial areas, the education, which you said you could get the records, medical records. We need much --

**COMMISSIONER CRAMER:** Law enforcement.

**COMMISSIONER BEVAN:** Law enforcement. We need broader sectors. And you said you could bring that together because there would be value in it, and I think that's the point.

I think that if a county or a state or a local government recognizes the value of an approach like this for them, that they're going to get something out of it. Right now the only thing states get when they're identified is a report card and they get whacked with a penalty, which never really gets put on them but it should be, but there is, you know, that's all they get out of this. They have no incentive to increase -- to improve their data or to deliver it to anybody because they're not going to get anything out of it. And this way, given the fact that you would be the third party and that it would require collaboration and, like you said, compromise among the states to get to this. We're not imposing a universal definition, we're not asking them to do that. But all the state statutes wouldn't have to change, we wouldn't need to do all of that.

The consensus would emerge, the factors would emerge from the states that participate and I think that they would participate. All these sectors would participate increasingly because it is voluntary and because they're going to get something out of it and because they are going to learn that they can trust. Right now there is absolutely no trust between any of these sectors. We had it yesterday. Child -- law enforcement in the same city, law enforcement and child welfare, you know, don't share data in the same city. I mean, here because you are a third party and because it's anonymous and they're not going to get outed and they're not going to get a report card or whacked, which is my approach actually but I'm compromising by listening to you and not wanting to kneecap them.

**COMMISSIONER PETIT:** Write that down.

**COMMISSIONER BEVAN:** This is big for me. I get your point.

**CHAIRMAN SANDERS:** Commissioner Covington has been trying to get in. I thought you were introducing a new subject.

**COMMISSIONER COVINGTON:** Oh, no. Well, basically around this topic.

I guess, as I've been listening to it, I think there's a few things. I think there's some misconceptions because this work is being done locally and there is really good trust in a whole lot of places in terms of sharing data and in terms of talking about these cases. I mean, that's what the death review teams do and that's what a lot of states are doing and local communities are doing around -- when they're having a critical incident debriefing or they're having their child fatality -- their specialized child welfare reviews of their deaths of their kids and they're sharing enormous sorts -- they're sharing enormous pots of data, they've got memorandums of agreement all over the place, you know, at both local and state levels. I mean, I point to places like Kentucky. New York City does it where they have a very structured review, a very structured report that they complete when they review a fatality.

Where I think the missing link is that, and it's something we try to do but we really haven't had the resources to do is to try to create a more structured approach for states and local communities, counties, where we might all be doing it somewhat more the same and looking at collecting the same kind of data and then being able to figure out where you put that data when you're done so it starts making sense. So I mean, I think that that's part of it.

I've got to correct the misconception that this work isn't being done because it really is being done in many, many places and they're doing it really, really well and they're learning a lot of lessons from it.

**COMMISSIONER DREYFUS:** Would they want to be part of this?

**COMMISSIONER COVINGTON:** May be, that would be maybe part of it.

And I kind of echo what David's saying. I mean, my biggest concerns is that so much complexity. Anybody that's ever sat and done one of these fatal child abuse cases, there's so much complexity. It's not just what happened with the boyfriend that morning, it's what happened with the worker and what else was going on and all the other -- the clusters, sometimes peeling back years of situational context to try to figure out what was going with these stories it's not simple.

I remember sitting next to a pilot on an airplane. Not a pilot. He might know one of you guys. I don't know. This is probably five years ago and his job was to do airline -- he was training the healthcare industry on the airline model. And we started talking about doing this for child deaths. And when it was all done his comment to me was, in an airplane you know where everything's supposed to be, you know where the flaps are supposed to be, you know where the wiring is supposed to be. When you look at human systems, it's just so much more complex, even more complex than a hospital system because there's so many moving parts.

**COMMISSIONER ZIMMERMAN:** A family system.

**COMMISSIONER COVINGTON:** A family system, a community system. There's just so many moving parts. And I think that's what our child death review programs struggle with or the places that are even within agencies that are trying to do their own internal reviews. I think that's what they struggle with is all the moving parts and how you make sense.

**COMMISSIONER DREYFUS:** Commissioner Covington, then how do you respond to -- how would you react to --

**CHAIRMAN SANDERS:** Commissioner Dreyfus, several people wanted to respond, like Commissioner Rubin, Commissioner Petit, and Commissioner Rodriguez all, as well as you.

**COMMISSIONER RUBIN:** I appreciate what Commissioner Covington is saying, too. There's also -- if you're not explaining a lot of variations, there's also the risk that your model may tell you to go -- you may introduce new problems. It may direct your worker to go work these families over here and suddenly you don't see the fact that this kid -- your intuition that this child over here because you didn't understand the complexity of the situation is actually at more risk, it may actually divert you away from a child who's at much more imminent risk.

Now, that said, I do agree with you, Commissioner Sanders, that the state of the decision-making in terms of the structured decision-making is such that you're probably likely to have a lot more gains in the communities that have it.

But in order to kind of think about an approach overall to this space, I'm trying to, as we move towards deliberations, I sort of think about a lot of testimony. Our research community is telling us, at least the research roundtable in Philadelphia for those of us who were there, we need to actually think about research that actually still sort of tells us sort of rates the sort of risk of the child, the safety risk, rather than just whether to substantiate or not substantiate. So there's clearly a research need about coming up with new sort of warning systems in terms of for these child welfare systems that can be very valuable I think to local child welfare systems if we can appraise risk from some of these models, what risk means. So there's a research in here.

I think we come away that for those that are ready, even before ready, there's a clear need obviously or data interoperability and so the commission's recommendations in terms of making it easier for local communities to access and share data more widely without having to worry as much about local MOUs or being sort of have lawyers sort of prevent the sharing of data on mothers or children, et cetera, if we can create capacity in there, that's going to spur a lot of innovation in this area and help a lot of communities out.

We have other communities like Native American communities and other communities that are very different. Chicago's analytics model is not going to predict very well what happens in Native American country; right? And we could think about -- I mean, for there, there are still places that need to collect data, is what I took away from that. So how do we help lift up areas that are so far left behind. And we could think of a place-based strategy the way the current administration thought about it that competitively some folks who were really left behind might actually, when they apply for grants if grants are what comes out of this might have some competitive advantage on some of those grants because they're so far behind and they've been identified as place-based strategies to try to lift them up to get them closer to where the average of the field is.

And then there's the appropriation for these systems that are engaging in this space with whatever vendors they're working with, whether they're doing it themselves, is there an innovation fund to allow them to develop these population management models so that they could hire the technical either within or outside the expertise and help them develop their algorithms, either around structured decisions-making or they're around sort of this is when we get the instant response team going, this is when we need law enforcement involved. Those types of decisions can be standardized more and can be helpful because they're sort of made very arbitrary. And it also could affect the disproportionality issue because the decision-making wouldn't involve certain interdisciplinary teams and not left to the individual judgment as much and is by some level of a standardized risk assessment.

So that's the way I'm sort of trying to organize this sort of whole space around data and what I've heard.

**CHAIRMAN SANDERS:** Commissioner Petit?

**COMMISSIONER PETIT:** I heard Terry say -- Commissioner Covington, about the work that's already being done. And I don't think there's any question that there's some great work being done all the over the place. But what we're talking about now and that are not mutually exclusive. This is this systems, metric system data that we get and that's the individual case. They're really two separate but related kinds of things.

And so for me one of the things, and Commissioner Bevan was talking about this, is bringing together all those different parties. I mean, there has been technology being introduced into the child welfare systems for at least twenty-five or thirty years. Huge sums of money have been spent on trying to create systems that work. The people aren't succeeding in doing it. And whatever we're doing, the kind of work that Terry's doing, all I have to do is look at the budget and know that it's inadequate. I mean, I don't think they're spending a million bucks a year on that thing and we're talking about something that -- we have succeeded in sending rockets to the moon and bringing somebody back, which I'm very impressed with. We haven't figured out yet a severely mentally ill violent individual with sexual assaults, bringing them back over the line. That is a more challenging thing to us than the other; right?

So I think there's utility in putting all this on the table sparking something nationally on it. And it can't be left to social workers and assistant DAs and cops at a local level on an individual case basis. Every two weeks or once a month the whole political world in Washington pauses and holds its breath while they get the latest unemployment data that

comes out. I mean, there are people that can be brought to bear on all this stuff in a serious kind of a way.

But we've been doing this for a year and a half and we're still discussing collecting data and its utility and all that. I think we need to bring this to a close. I don't mean this conversation here. But I think we need to say this is what we think it is that needs to happen. We're not going to be the ones that do it. Somebody else is going to say good try but it doesn't go far enough or it goes too far. But how many more conversations do we want to have on this knowing it's important but I'm thinking the rest of the lineup that we have in the next month or so.

**CHAIRMAN SANDERS:** Commissioner Rodriguez?

**COMMISSIONER RODRIGUEZ:** I'm sorry I missed your presentation this morning but I did have the chance to go see the headquarters in D.C. And I think the thing that struck me about seeing your presentation there that I thought a lot about since is that I fly a lot and I'm a worrier. And after seeing the type of analytics that you're doing constantly with flight takeoffs, with looking at speed, I felt a lot of reassurance that there is -- that people have decided that this matters and that you are working like unbelievable -- in unbelievably sophisticated ways to try to make sure that I am safe when I'm in the air, and that is never a feeling I had when I was in foster care, and even more so less even after hearing testimony across -- I think people care but as a society, we are not sort of taking the approach that this really matters and we're going to deploy all resources to making sure that children stay safe. And even in the most sophisticated jurisdiction, and there are so many wonderful things that are happening. I mean, hearing Chet Hewitt yesterday in Sacramento where they zeroed down on zip codes, that's a step towards the direction of what you all are doing where you are able to pinpoint the problem as exactly with a slow landing on or unstable departure. That's getting closer to there but it's not all the way there.

And I sort of take for granted technology because I was born with technology and so I'm constantly sort of floored that in our child welfare system we don't take advantage of things that are easy for me to do on my phone without thinking twice. I can find everybody that I went to middle school with like this but yet we still can't find fathers and paternal family.

So, I mean, to me I think that not only does this make sense from sort of a clearly we need it, we need the data analysis, but I think it also makes sense from a prioritization. We have decided that it is important enough that when people fly, their safety, that we're going to make sure that we are not only looking to try to peel back all the layers and to get to the institutional factors that created accidents, which is part of what we haven't really been able to do. Even in New York where they're doing so many impressive things, I look at here all the things that they're doing and look at the death numbers and can't make sense of why the death rates haven't drastically declined here given all the wonderful things. But I know that's because my brain doesn't analytically pull things together, it can't pinpoint zip codes, it can't figure out where the mistakes are being made, where the capacity exists here.

So I think my plea would just be ask other commissioners. I think that this is a reflection of the importance that we've put on air safety. I think we have to elevate the importance of

children in our child protection system to sort of the same level because I think it's just as if not more important.

**CHAIRMAN SANDERS:** Commissioner Dreyfus?

**COMMISSIONER DREYFUS:** That was really fabulous. Thank you. No, seriously, that was just beautifully and it framed this really well as to why this matters, so thanks for that.

Just two things.

Having stood up two SACWIS systems, one in Wisconsin, one in Washington, I can envision if I were doing this -- if this happened and I was in the position of having to stand up a new SACWIS system, God forbid, in five or eight or ten years from now, I think this approach would change the technology systems, right, because we would start to make the right changes to them, law enforcement would be changing their systems, healthcare, all the players as we were learning more, I think our data would all get better, right, and I think it would have an influence on the technology systems across the multiple players. I think it gets to your point. So that's one thing that I just wanted to say. And I think there's a bigger benefit to this and I think it would not just in a child protection space in terms of technology improvement and data improvement.

But Commissioner Covington, I wanted to get back to your point. And I just wanted to ask you, in the complexity of family systems, how do you then wrestle with Hillsborough County and the fact that yes, with all the same complexity of family systems, they really have found that using predictive analytics that was more than just what's sitting in the SACWIS file because they've got I think ten different data sets that they're looking at, they are predicting in real time children who are at serious risk of serious harm and the family systems are just as complex and it clearly has had stunning results, at least so far. So I just wanted to ask you that. Because I think you're right -- you and Commissioner Rubin both about the complexity of family systems. It's like the commander yesterday sat here and talked about triggers. How do you know the guy's going to, you know, snap? But I just wanted to ask you about that, about Hillsborough.

**COMMISSIONER COVINGTON:** I don't have an answer.

**COMMISSIONER RUBIN:** I can answer.

I think Hillsborough is the prototype. I think Hillsborough is a great example. Look at what they had in Hillsborough. They were able to share a lot of data, right, they had a very open platform for every Medicaid data, schools data, they were able to get through all those hoops and did some really innovative stuff around sort of analyzing case notes and natural language processing, et cetera, finding out when visits were missed. They really did a front end sort of they thought heavily about the kind of things that social workers in the front end actually when they didn't do those things, they indicated and elevated risk. So they were able to explain a lot of variation, not all of it, because I actually had a separate conversation with the mind share guys to try to understand what they had done. But again, it was a population attributable model. They knew they had a very young workforce and they had a limited number of really senior supervisors and it was all about trying to figure out when a senior supervisor had to look over the shoulder of a junior person.

**COMMISSIONER COVINGTON:** And it kind of goes to my point which I think a lot of this has to be done local. I mean, that's sort of where I was coming from in my comments. I'm not against - - believe me, I'm not opposed to this idea, I think we need it, but my concern is I don't see it being done where you're feeding everything up into some big huge national database without really having a local context. I think a local context is really, really important.

**COMMISSIONER RODRIGUEZ:** They're simultaneous, yeah.

**COMMISSIONER BEVAN:** Can you respond to that?

**CHAIRMAN SANDERS:** Let me check. Commissioner Martin, you were next? Do you want to wait for the response?

**COMMISSIONER MARTIN:** Please.

**DR. THOMAS:** Could you please restate --

**COMMISSIONER PETIT:** Let's just not forget that at Hillsborough County, they went back and looked at all those cases. They did those rear window, rear mirror reviews which was I thought an important part of why they had such great results.

**COMMISSIONER COVINGTON:** I'll raise the question, and I actually was in the back watching your presentation.

What concerned me was, as you were describing your model, it looked like it was at a national level you would be taking this information and throwing it up into this big national pot. My concern is I think the better lessons are learned locally because you've got local context in terms of -- I mean, there's so much variation even in how systems work. The different child welfare systems are different state by state, there's just so much variation. My concern was thinking about it in a big national pot where you're feeding a lot of information instead of thinking more local.

**COMMISSIONER RUBIN:** The question are we ready for a national repository or should the money be invested locally to the assistance to allow them to develop their own systems. So that's the fundamental question we've been arguing.

**CHAIRMAN SANDERS:** And before you jump in, I would offer that one of the issues locally is the numbers aren't big enough and I think that's been the issue we've talked a lot about whereas at a national level you can do the kind of analysis and understanding the compromises, that's why it seems like it has to be both. But you have to have numbers at a level that you can do some of the analysis. Unless you're in a New York or a Los Angeles or a Michigan measure, you're probably not going to have those numbers.

**DR. THOMAS:** I would say that, in my view, I don't know that those two approaches are mutually exclusive.

Well, again, my personal opinion would be that if you don't make investments at the local level you'll never have anything of value at the national level. But on the same token, if you don't have that national framework and picture, you're not likely to learn as much as you would be able to learn otherwise because you're now able to look at your large numbers and look at trends. I'm thinking about the aviation example. You start out with seven entities,

that was local, right, with a discrete number of organizations and then they were able to build from that value that now it's become a national model. A similar approach is happening in the patient safety work that we've done.

There's three hospitals that are committed to making a change and have been able to grow from that, but the perspective I believe is that we're not just trying to change the world in our community, we're trying to do things in our community that allow for us to change the world or the larger context. So I think that's sort of like building train tracks from coming from different directions. You want to make sure that they meet in the middle and that you haven't made an investment for technology standards it's been established that now can't be rolled up into a national system.

And the dashboard visual that we put up there from our patient safety work, it's nice because they can see what's going on in the aggregate but they can also see what's happening at the local level. And so I would assume that most hospitals spend some time looking about how they're comparing to others but they're also able to really focus okay, what's happening on this patient, this case, doing that more local analysis.

I guess I just come back to my thought that I don't know that they're mutually exclusive.

**CHAIRMAN SANDERS:** So Commissioner Martin?

**COMMISSIONER MARTIN:** So again, I have a couple of concerns. And the more we have a conversation around these issues the more I think I'm getting concern about some of the issues that we've been talking about for the last year and a half that are particularly germane to communities that aren't in Chicago. I still have concerns about this is based on data but I have communities that I really care about that don't have any data. So what do we do there? And my response to the fact that, you know, we need to start at a local level, we've been starting at a local level since we started juvenile court in Cook County two hundred fifty years ago and we're getting the same results, so we need to do something a little different.

And I guess my other major concern is, you know, I'm in a court system, I'm not in a research arena, and part of my problem is that there's so much research going on but I don't get it. There's no connection between that research and what's practically happening in my courtroom every day, and so I need someone to help me analyze the data. Cook County, I'll give you data every month. I collect data, the department collects data, the clerk's office collects data, I bring it all together every month. My problem is what does this say, what does this tell me, and how should I change the practice in the courthouse based on this data?

So the value I'm looking at this project is you telling me what that means and how I can use that data to improve my practice to improve the lives of my kids on a daily basis. That's where I see the value here. I could care less what the data says really if it doesn't help me eliminate the deaths of my kids every day.

And so can you talk to me about, you know, if, in fact, we somehow figure out to get Indian community to get the data to you, we get large jurisdictions, we get small jurisdictions, we get rural jurisdictions, we get urban jurisdictions, we get a real great mix of data to you. How do you take that and analyze it and get it back to the street, get it back to the worker, get it back to the judge so that I can understand what you're telling me this means?

Do you understand my question?

**DR. THOMAS:** We'll find out. I believe so. And Ed can probably speak to it from the processes that they've established in the aviation community to be able to get information back out to people sort of on the front lines, if you will.

**COMMISSIONER MARTIN:** But excuse me, see that's my problem. The aviation community has standards already. I don't have a standard from child protection agency to child -- I mean, look, the medical community has standards. This is the standard practice in doing a hip replacement from Chicago to Timbuktu. I don't have any standards and that's why this worries me.

Do you understand where I am? I don't have a framework already built to transmit that information, to utilize that information, to get that information from one place to another. And so you could do all the great work in the world but if I don't get it, it's for naught.

**COMMISSIONER ZIMMERMAN:** We still don't have definitions.

**COMMISSIONER MARTIN:** Without having -- and that's my problem. When I look at aviation and the -- and don't take my question wrong. I'm not trying to challenge you, I'm just trying to connect what you're telling me and how I see my system; okay?

And so when you tell me about aviation, I don't know how to fly a plane but I sure know to find someone and they're going to fly a plane the same way in Chicago that they do in San Francisco basically. That is not true in child welfare. In hospital, I will go to Belvedere Hospital next door and I can go to St. James in Chicago Heights in Illinois and presumably they do a hip replacement kind of the same way. That's not necessarily true in child welfare.

**DR. THOMAS:** So the data from healthcare systems would suggest that there isn't as much standardization as most patients would hope or assume in healthcare.

So I want to highlight the importance of governance in the partnership because that's where those standards can be generated, that's where the decision-making can be made around what research should be done.

One of the nice things about the patient safety and the aviation safety model is that those partnerships don't impose a standard on the stakeholders. It can certainly provide benchmarks and, you know, provide people access to maybe a federal benchmark or other benchmark that might exist but there's enough diversity -- there is a lot of variability and so they're able to give filter and adjust the data against their own measures. If they define a fatality differently in a certain state, they can put their definition into the system and see how they're performing against their standard but someone who's a policy maker at the federal level who may want to look at it differently also has that flexibility.

But I think the cycle between the governance, you know, deciding what studies need to be done, how the results of those studies then need to be communicated back, having that feedback loop and understanding, you know, this intervention resulted from the findings of the study and interventions took place. Well, what was the impact. And then feeding that back into the system. So it's a learning system that can help create some standards and some guidelines for things that may not exist at the moment.

**EDWARD WALSH:** Yeah, that's exactly right. I think that the key that Mark mentioned is the collaborative nature of the governance model that's in place. And I can give an example from aviation that I think might answer or help with -- help you understand.

An unstable approach is one where an aircraft is too high, too fast, not properly configured from three miles out of landing to the runway. Anecdotally everyone agrees what an unstable approach is but when you get down to the details of what the specific criteria are, the thresholds to exceed those criteria, it differs from one airline to the next and each airline is going to measure something slightly different in their data.

So when we set up our ASIAs study looking for the -- the aviation study looking at these unstable approaches, we were looking to develop a consensus agreement, a consensus definition and we convened a working group within the partnership consisting both of government and industry members to develop what that consensus definition was. So we would have agreement across all the different players on exactly what it is that's going to be measured and we took that consensus definition and applied it to the data and that's what we reported out.

So the definition that is measured and tracked is going to be different from what each of the different participants measure themselves but it is that consensus agreed-upon definition that is taken and applied to the data and that's what's tracked and trended within the partnership.

**COMMISSIONER MARTIN:** So I'm American Airlines and I might define it one way but when I report my data to this group, I define it a way that the group -- the governing body developed this consensus definition?

**EDWARD WALSH:** So the airline is just contributing their data to the partnership and then it's our role as the data stewards to take that data and run the analytics.

**COMMISSIONER MARTIN:** And then translate it to the definition. I got it. Thank you.

**COMMISSIONER COVINGTON:** So can you tell us which airline had the safest approach?

**EDWARD WALSH:** I plead the fifth.

**CHAIRMAN SANDERS:** We have two last -- we'll make three last comments and then we'll move away from there. Commissioner Cramer, Commissioner Petit, and Rubin.

**COMMISSIONER CRAMER:** I want to come back. If I heard -- I see tremendous benefit in a federally-funded research and development center that is looking at data from voluntary participants, I assume. And let's say we line up the communities that need to be lined up; rural, urban, Native American, that sort of thing. You're collecting data but there's an evaluation piece to this. You take that data, you give back an analysis of the data, and you evaluate the data so that you can make recommendations back to those various participants that are in the system; am I right?

**EDWARD WALSH:** So I would say you're partially correct. It's not our role as the data steward to make recommendations. It's more that the partnership that's meeting and getting together and viewing the results that's making the recommendations and conclusions. We collect the

data, we ingest the data, we run the analytics, but we rely on input from subject matter experts across the partnership to help interpret and provide the direct --

**COMMISSIONER CRAMER:** Well, in this process surely you get to a point where you say we need more data than we're getting in order to evaluate or maybe not draw conclusions but to analyze this. You help streamline and make more efficient the data that's collected and that the participants are giving to you. Is that a dynamic process?

**EDWARD WALSH:** Yeah, we're always looking for more data sources that can help us to better calculate and report on what it is that we are identifying by analyzing all these -- we're constantly looking and trying to identify better data sources to help us improve upon our analysis.

**COMMISSIONER CRAMER:** And then -- we've consumed a lot of time. This is very good information we're getting. I want to come back to the funding side of this. Going to the patient safety program, how is that funded? Where does that money come from? What is the cost for that?

**EDWARD WALSH:** I'm going to defer to Mark on that.

**DR. THOMAS:** That's a MITRE internally-sponsored initiative so there is no source of government funding right now. That came out of our internal research and development program so MITRE assumes the costs for that.

**COMMISSIONER CRAMER:** Can that be done for this issue?

**DR. THOMAS:** So again, it's an internal research and development program. It's intended to sew seeds, if you will, to prove the concept but then we can hand back over to our government --

**COMMISSIONER CRAMER:** So in other words, that's your internally-funded demonstration project?

**DR. THOMAS:** Correct.

**COMMISSIONER CRAMER:** And is there some possibility that you could do that here?

**DR. THOMAS:** So essentially the hope is that enough value is demonstrated in this partnership that it can then be handed off to another organization could be -- the government decides that they want to fund something like that on a national level, it could be a hospital association or some other organization. MITRE exists to serve in the public interest so we don't hold on or own any of the ideas of innovation, we want to push them out and give them to whoever needs to take them to make an impact. So the patient safety initiative is of that nature, if you will.

**COMMISSIONER CRAMER:** Did the aviation project start that way as well?

**EDWARD WALSH:** So the aviation safety work came to MITRE in October, 2007 as a government-funded program. It grew out of a -- and I could spend a day talking about the history and evolution, but it grew out of a prototype that was started in 2003 or so time frame. It was much smaller in nature than what the current partnership looks like now. But I

think it was much more in line with the scope that Mark has described with the patient safety work.

**COMMISSIONER CRAMER:** Thank you.

**COMMISSIONER PETIT:** I think we have been wrestling with this right at the beginning and we've been actually wrestling with it for a long time, but let me just draw some conclusions about this. One is there's a huge amount of freelancing going on in the child welfare field. We know there's gigantic variation between each states and within states and even within say a child protective unit. When we look at eight indicators, as I have on numerous occasions, that measure activity in child welfare, kids removed from families, substantiated abuse rates, reporting rates, et cetera, the variation is never less than a hundred percent to two hundred percent difference from the number one to the number fifty, sometimes it goes up to tenfold.

With respect to the question of standards, we have volumes of standards. The federal government has standards, the Council on Accreditation has standards, the Child Welfare League of America has standards. One of the things that I don't hear, and I think it's a plus from the aviation industry, is you don't have elected officials at a state level, you don't have elected officials at a local level to deal with on the big issues. They're largely federal and they're largely the airlines themselves. That's a different situation than we have at the state level.

The other thing that I would note is that -- this action of geography. We know that you're better off -- if you're going to be injured, you're better off being injured in one state than another state in terms of what the response is going to be, whether it's caseload levels, whether it's training, whether it's experience. So there's just this wide variation among the states and at some point is the federal government on top of this, are they exerting strong leadership the states must comply with in order to receive federal support, and are there national standards? And I keep returning to this notion of are they Mississippi kids first or are they American kids first? And this business with the states not putting data on the table approaching a lot of different ways, look at the outcomes.

So for me this is a critical piece that needs to be standardized and driven by the federal government. I think we can reduce that to yes or no proposition at some point.

**CHAIRMAN SANDERS:** I would just say, because you asked the question a couple of times, it seems we've primarily dealt with the issue of production of data and less of the analysis and application I think that's what this is more so. I think that's what this is more so --

**COMMISSIONER PETIT:** I agree.

**COMMISSIONER DREYFUS:** And those aren't mutually exclusive topics. One will drive the other.

**COMMISSIONER PETIT:** Once they get into this, I know that people can forget, you know, our friends here. But in terms of the states and the governments and all that, once they get into this thing they'll figure out how to manage and administer this well. I mean, part of this, and Commissioner Martin talks about how does it get applied locally. That's exactly right. Somebody ought to be, whether it's in Springfield or whether it's in Washington, working with local jurisdictions or standardizing it or whatever it is so that people can draw on real

information that they can use, whether it's an individual case or whether it's a systems situation.

**CHAIRMAN SANDERS:** Mr. Rubin?

**COMMISSIONER RUBIN:** Yeah, I started out, you know, this session very skeptical, right, and then I think your last answer helped me, is it a local strategy, is this a national strategy, are they mutually exclusive. And it sort of popped in my head, I'm baking this, so potential opportunity; right? So unless we get federal some legislation to handle the data sharing issue, which I hope we'll try for, right, when you said you weren't a vendor, I could see you're a collaborative, you're sort of the institutional framework for supporting an industry collaborative. But what if the cities and the localities that were participating in this approach, A, if they participated they would get some financial support for aggregating their data and their participation so there's an incentive for cities and localities to participate but only if they shared the following data sources; right?

So there's a unique opportunity to incentivize through the funds flow that you have to provide us schools data, you have to provide us child welfare data, you have to provide Medicaid data. And so there may be an opportunity to build in an incentive for local communities to work through their confidentiality issues because it may mean that they can participate in a larger collaborative and help them develop more standardization. And then at the end if this becomes large, well, then you could also archive these data so the research community, right, would have access, just like they do to other surveys, to be able to really work with these data whether they wanted to take a local approach, a cultural approach, et cetera.

So there might be a vehicle here -- I can see where this is going -- to really kind of really elevating this into an opportunity to have richer data and then let the smart people out there to figure out how we're going to use that data and then really apply it. It doesn't diminish the need for local investment to allow folks to standardized or do stuff locally. But I can see something emerging there that could accomplish -- now it doesn't address I think the communities that are so far behind. I think the strategies there are very place-based and need their own thought on how do we lift up those who are not able to participate in this because they don't even have data. But I don't want to hold back the communities that might be ready to do this.

**CHAIRMAN SANDERS:** I think that we're way past. If it's something quick, go ahead.

**COMMISSIONER MARTIN:** We can't keep forgetting the communities that don't have. I mean, we keep saying that, they don't have, they don't have, they don't have, and then we keep putting them off and saying, well, we can't keep waiting until they get. But we no longer can afford -- I mean, we have poor communities, we have rural communities. We can no longer afford to keep putting them off.

**CHAIRMAN SANDERS:** Well, thank you very much. You've certainly generated a lot of conversation.

We're going to take a break before we go into the disproportionality session, so we'll break for fifteen minutes and reconvene. Thank you very much for your time.

(Whereupon a break was taken)

**CHAIRMAN SANDERS:** We're going to get started with our next part of the agenda which is the discussion from yesterday's series of presentations on disproportionality. So I wanted to turn that over to you, Judge Martin.

And we have a summary that's been handed out.

**COMMISSIONER MARTIN:** Thank you.

Ladies and gentlemen, if you were here yesterday, we did, in fact, have testimony regarding overrepresentation of minority children in foster care and their deaths. So before you, you have basically a summary of the recommendations that were provided by the persons that offered testimony yesterday. The only thing -- and we can go through it; there's no need for me to read it to you line for line. But I would ask you to note the last line of Dr. Rita Cameron Wedding. It's not really a recommendation; it says note.

The one thing I wanted to just put in here was that she was speaking of what disproportionality really included and she was trying to make certain that we recognize that it is more than just the overrepresentation of minorities, that it may, in fact, also include, particularly when we talk about head trauma, the underreporting of Caucasians and the majority. And so it's not just a black thing, if you will, or a Hispanic thing but it really does affect all of our children.

So the idea is that as our committee reviewed the testimony that was offered yesterday, we kind of pulled out specifically just the recommendations, if you will, so that we could utilize this as a basis of conversation for the commission and kind of formulate where we want to go regarding potential recommendations in our final report. And so if anyone has comments, conversations about this, we're more than happy to entertain those.

**CHAIRMAN SANDERS:** Commissioner Martin, would you prefer to operate off the document or off of our recollection? Because there are some comments I have. I'm just not sure --

**COMMISSIONER MARTIN:** Sure, we can go off of your recollection, it's fine.

**CHAIRMAN SANDERS:** The one thing that I was struck by was the -- were some of the comments from Chet Hewlett about Sacramento. And six neighborhoods with eighty percent of the fatalities, the thinking through what the strategies would be in six neighborhoods but recognizing the potential impact that has, could have on a community. It seemed that, and I think Commissioner Rubin has mentioned this several times, it really seemed to emphasize place-based strategies and the importance of those strategies and that I don't know what the result will be in Sacramento but a system that focuses on individual pathology and pays for treatment of individual pathology it seems cannot get to the addressing the needs in six neighborhoods in the way that we ultimately would see necessary. So it just seems like something we haven't talked about payment structure as much and it may be something that we need to think about.

**COMMISSIONER MARTIN:** I would agree with you. I think it's something that has been put on the table by Commissioner Rubin I think for a while, actually, in different settings and so that probably is a conversation that we should have on a greater scale for us.

**CHAIRMAN SANDERS:** I have to imagine in Sacramento that those -- that it coincides with the segregation in neighborhoods, so I think that being a big part of the link.

**COMMISSIONER MARTIN:** Commissioner Rubin, you wanted to say something?

**COMMISSIONER RUBIN:** I just wanted to say I thought it was really helpful from the group yesterday, because I've struggled always with overreach, and you and I have talked about this a lot, which is in trying to do the right thing we overreach and we place a number of families under the supervision of the system or under the eyes of a system unfairly; right? And I actually thought it was very helpful to the discussion of data, for example, how we share data and that there wasn't a fear of sharing data. In many ways, there were also some potential upside in that there is a comment things might get worse before they get better. And so I thought that was really helpful and made me feel a lot more comfortable about the conversations around data sharing.

You know, was that your impression as well?

**COMMISSIONER MARTIN:** It is. But I also think that it has to be taken into consideration that these are small pockets. I think that's widespread; right? I don't think it's -- I mean, speaking to the majority of people I don't think there's that level of comfort in sharing data like it is in this community, and that's kind of the issue. You know, we find pockets across the nation that find ways in which based on personalities, based on relationships they develop a trust and a willingness to share and I don't think we find that widespread necessarily across the nation.

Are there any other comments, questions, concerns that came up yesterday?

I guess --

**COMMISSIONER PETIT:** I just got this.

Can we just take another minute to read it?

**COMMISSIONER MARTIN:** Oh, absolutely. This doesn't have to be the last conversation.

**COMMISSIONER PETIT:** No, no, but I mean right now I'm not asking questions and I'm trying to read what's right in front of me and I may or may not have a question.

**COMMISSIONER MARTIN:** Sure. And please, Commissioner Petit, your question, it doesn't have to be based on just what's in front of you. Anything that happened yesterday in the conversation is fine, too.

**COMMISSIONER PETIT:** I guess I have a question or a comment.

**COMMISSIONER MARTIN:** Please.

**COMMISSIONER PETIT:** And I failed to ask it yesterday but I thought about it afterwards.

The first encounter I recall facing this disproportionality issue was twenty-five or thirty years ago, the first time it was raised as a topic, the words "disproportionality." And I remember the block administrators in child welfare, that was affiliated with the Child Welfare League of America, this was a topic that they embraced and then at some point NICWA and others embraced it. So in looking at what it means -- and there have been conferences, books,

trainings, all kinds of activities on this topic and here we are twenty-five or thirty years later still raising it as an issue. I'm not sure what progress we've made on it.

And I'm wondering -- and I really should have asked them yesterday but you've been working with New York on this issue, what is it at this point that is making this so difficult for us to address? The field, we'll start with the field which should be particularly enlightened on this question -- forget the general public and policy makers and the press for the moment but just the field, why are we having so much trouble on this issue?

**COMMISSIONER MARTIN:** Well, I think in the context of this commission's work, the reason it's so vitally important that we address is it's not so much the overrepresentation of minorities in foster care as it is that the number of black children who die due to cans or death is so much greater. And so the point I'm asking this commission to consider by bringing forth these experts in this area is to recognize that it's important and that we owe -- and we have a responsibility to look at this issue and find out why there are so many of our black children dying.

**COMMISSIONER PETIT:** So let me ask you, on that specific question, what was raised yesterday and repeated often was this notion of implicit bias and maybe yes, maybe no.

But in terms of the environmental forces that more black children are raised than white children which is best expressed in poverty rates double, maybe higher. So my view of it is that there's a harsher environment for black children collectively in the United States than white children because white children aren't as poor compared to black families. That that in turn -- so we know that poverty doesn't cause child abuse or neglect fatalities but we know that it creates a stress that can contribute to it. And I didn't hear a lot of talk yesterday about the environment that some of these kids are raised in.

**COMMISSIONER MARTIN:** Well, if I understand information that I've heard out in the public that there are more white families in public aid in America than there are black families, if I understand --

**COMMISSIONER PETIT:** Sure.

**COMMISSIONER MARTIN:** Wait, you asked me a question. Let me finish.

So if we're looking at just poverty, it's not necessarily true that there are more black people who live in poverty. And poverty in and of itself is not a reason to bring a child into foster care. I agree that it's one element to look at, it's one risk factor. But I do think, as we've talked about for two years now, that it's a multiplicity of risk factors that subject our children to high risk of being killed or being put in risky situations or close to death situations. And so our enacting legislation asked us to look at poverty. I do think it's a factor that we should look at. I'm not asking us to cure poverty. I'm asking us to look at poverty as one risk factor in addition to the protective factors that black families come to the table with.

So for instance, this is what I'm asking us to consider. As presiding judge of Cook County for the last fifteen years, I've had a number of babies who have come into foster care because they were born with cocaine in their system. None, not one, none, none, of those children came from a private hospital. They all came from a public hospital. The majority of those children were black and Hispanic.

Now, I can draw a lot of conclusions from that sitting over at the courthouse. One is that white people, white women who are of childbearing age who come into the emergency room at 2:00 in the morning underweight, no prenatal care, deliver a baby that has cocaine in their system all have resources or I can look at why black and Hispanic kids are called into DCFS and the white kids are not.

And so all I'm asking us to do is recognize that that happens on the street, recognize that happens on the ground, and look at how we can also find the protective factors for my black and Hispanic families similar to the way we find protective factors for my white families and treat them in comparable ways. That's all I'm asking us to do.

Yes, Commissioner Rodriguez?

**COMMISSIONER RODRIGUEZ:** I also think though that there are some systemic policy changes that we could recommend beyond just looking at sort of people in comparable ways. I mean, one of the things that I think of is when you hear sort of what some of the risk factors are and how children are killed, it's clear that there are many women who are in situations where they don't have child care who are leaving their babies with somebody who is -- who really, if they had appropriate child care, they wouldn't leave their child in that situation. That's what we have heard as sort of it's a man, an unrelated male in the house, these are families that are poor, stressed, the mother is trying to work.

So taking a step back and looking to see are there things that we can do -- I mean, child care is such a basic sort of fundamental piece of any family who's under stress, and I'm sure that's just one example of the type of policy that I think could help equalize, but I also think about David's comment earlier about what Sacramento's doing and Chet.

I don't know a lot about what their strategies are but I'm also imagining that any place-based strategy in the zip codes that they identify is actually going to look at how do you utilize and strengthen up community organizations, churches, families, how do we deal with issues of poverty in those communities. And so I think it's more than just a culture change that they're going to look at sort of in asking people in the majority and the decision-makers to evaluate the cases differently, I think there are going to be some real resource issues.

So I haven't thought through what all of those resource recommendations or policy changes might be but I know, as I've heard sort of the stories over the past year, child care is certainly one of those very basic things that keeps arising.

**COMMISSIONER MARTIN:** Commissioner Zimmerman?

**COMMISSIONER ZIMMERMAN:** Thank you.

So I guess commenting off of what Commissioner Petit commented on, I think that what this panel yesterday did for me was, as a commissioner of color, is give us finally permission to talk about racism in the child welfare system and the other systems that serve children in a way that's thoughtful and intelligent and hopefully helpful. Because I can't find a reason why seventeen percent of the Alaska native population is children of that entire state but over fifty percent are in care. In South Dakota it's something like thirteen percent of the entire South Dakota population are American Indian children but they're almost fifty percent in care. It's not that we're pathological people, it's not that we're all that poor at parenting. There has

to be other things to bear, there's got to be other issues contributing to why the caseloads are so disproportionately children of color.

So Nassau County here in New York has done this sort of let's remove the neighborhood, let's remove the race of the child when we think about removal and they've reduced the removal of children of color just because the people sitting around the table making the decision to remove or not don't have that race bias that they have to deal with -- it's a blind assessment - - which I think is a fascinating potential way of doing removing assessments, safety assessments, but we wouldn't have that conversation, there wouldn't be that sort of thinking outside of box of how to address it unless we are comfortable having this conversation about why children of color are so disproportionately in care. It is not -- it's not as I think it was Dr. Canady said it's not about race, it's about racism.

**COMMISSIONER MARTIN:** Commissioner Rubin?

**COMMISSIONER RUBIN:** You know, I actually love what Chet is doing in Sacramento. I actually believe that place-based strategies are -- hold huge promise. I think that the administration has taken some steps in terms of the competitive advantage for grants but I think we can take even bolder steps in terms of defining what does it mean to have a place-based strategy. And it's sort of like those plans that we had talked about. But, you know, show us how it's easier -- I remember Dr. Canady said yesterday, no one wants to live in poverty; right? And so I have found in my own career when I have a young teenage mom who comes into my practice who is from one of these neighborhoods, right, but she wants better for her child and I can't connect her to a service and no one is available because there are waiting lists or this or that, you know, that is a huge fundamental failure because part of the equation - - it's voluntary -- is motivation; right? And I can tell you that teenage mom, there are some that are just drifted and they're not going to respond well even if we give them the intervention, right, and then there are some that really are motivated.

And so place-based strategies, if there were standards in terms of how you connect people to services, how do you make it easier for them to access services, how do women access MIECHV programs, how do they access, you know, opportunities around reproductive health, et cetera, their own health, the child's health, you know, issues of trauma, and how those are linked in a way that's accessible to people in communities so for those to help folks empower those communities, that's what Chet I believe is trying to do and I think that that is the promise because it's a population model of eighty percent of the deaths are coming from those six communities, you know, that's how you would do it if you were a smart city.

**COMMISSIONER MARTIN:** Commissioner Dreyfus?

**COMMISSIONER DREYFUS:** So I thought about this a lot last night and I loved the people that we had, so thank you. I thought they were fabulous. And I thought, okay, so what could we do as a commission, where could this be going. And I came to two things.

One is, and it connects a little bit with MITRE, I didn't think about that last night while I was listening to them today, but I can envision this commission talking about -- and I'm just going to make up numbers for the sake of putting something on the table -- I could see this commission talking about in number of neighborhoods across our country using data analytics that have a high percentage of child fatalities from abuse and neglect. The opportunity to do

place-based work using places like Sacramento, Wichita, there are other examples of this kind of work going on locally where the goal is to reduce child fatalities from abuse and neglect and look at the overall improvement of the well-being of the community but only if these folks are connected as a laboratory; only if there's something that connects their data, that connects their best practices, that connects what works and doesn't work so that it becomes a learning laboratory for the whole nation. So that's one thing I thought of.

The second thing I thought about though is I just don't want us to walk away from the discussion of implicit bias and racism. Because I, like Michael, have been talking about this in child welfare since the early 90s and we're still talking about it. And it's because we're not wrestling with the five hundred pound gorilla in the room. And so I would like to think that this commission would make at least some very strong statements and some recommendations on what it's going to take to move the needle on implicit bias in the child protection system and within courts and law enforcement, some of these systems that are interacting with these families more often than not. So that's what I came down to. It's kind of like those two buckets of ways that we might come at this. But I really appreciated yesterday. It was fabulous.

**COMMISSIONER MARTIN:** So I think there are a couple of things that -- oh, I apologize, yes, Commissioner Rodriguez?

**COMMISSIONER RODRIGUEZ:** Well, I just wanted to say that I think linked with the implicit bias is also, and it was brought up yesterday, it's the way that we work with families and with children as well that are impacted that none of those systems tend to work with families as if I'm a mother talking to another mother. We very much have a client sort of -- and I also want to say that in terms of our charge around poverty, I mean, what we ask families basically to do when they get involved with the child protection system is we ask them to get themselves out of poverty in order to get their kids back; we tell them they need to find adequate housing, they need to find employment, they need to have -- to be financially able to care for their kids. This is what we ask of families. And going back to nobody wants to be in that predicament but often they've ended up there because they don't have those things and then we tell them in order to get their kids back they've got to solve it on their own.

So clearly it seems like we should be thinking about how do we put some of those things in place so that it makes it possible. But anybody who's actually supported somebody in the process of trying to get their children back has seen how impossible it is to have them face all of the systemic factors that are attempting to push them down on their own.

**COMMISSIONER MARTIN:** That brings up what Dr. Canady, right, that poverty is a condition, not a character flaw, and sometimes we as a system kind of look at it as a character flaw.

Mike, did you have your mic on because you wanted to make a comment?

**COMMISSIONER PETIT:** Yes.

**COMMISSIONER MARTIN:** Oh, please.

**COMMISSIONER PETIT:** There's some characteristics -- poverty, too early parenthood -- that individuals are wrestling with. There's huge issue around a social safety net question that addresses some of the things that you were just saying. And I remember back in 1971

predicting my worst prediction ever that soon there would be universal child care in America and we've gone in the opposite direction. We're not doing any better today with child care than before.

But as we sit here and discuss this, and we haven't spent a lot of time on social safety net though I suppose all this upstream talk is really about that and that's likely aimed at means testing for the most part, but at the same time we're having this conversation the Congress, as presently constituted, there are budget proposals being put forward that would cut, reduce, eliminate much of what it is that we're talking about. So I think we need to also put this within a political context as well, and I don't mean for the committee to be political or to be partisan but I think there's clearly something missing in which several thousand children are killed each year. We know a lot about how to stop it and the measures that would help contribute to that are proposed to be reduced rather than be increased.

So I think somehow, and we have a former member of Congress serving on our panel who I think should maybe weigh in on this as well, Bud, and people like Cathy -- Cathy has worked on this and all of us have been involved in one way or another -- but I think we have to acknowledge that the social safety net in the United States in comparison to our other western brethren is weaker, it's weaker, and how is what we're doing going to strengthen that. Because as you said, you can't just dump this on the backs of all the individuals saying take more responsibilities. I mean, a lot of this stuff is systemic, it is political, it is policy, it is politics, I mean that's so -- and we're just a few months away of putting something out on the table. So I think we ought to bat this around, and it relates very much to this disproportionality issue, I think.

And Marilyn, it seems to me that when you raised that question about the disproportionality in the overall representation, is it your belief, as is mine -- correct me if I'm wrong on this thing, but the environmental hazards has nothing to do with morality, has nothing to do with character, just the environmental hazards that most native children face is a more severe environment because of poverty, because of domestic violence, because of whatever, or am I misreading that? Do you think it's the same, is it the same opportunities, the same poverty situation?

**COMMISSIONER MARTIN:** So let me go to the people that have their mics on and then if she wishes to respond, I'll get to her.

Commissioner Bevan?

**COMMISSIONER BEVAN:** I just want to make sure that we don't lose sight of the fact that racism in and of itself is not the cause of the disproportionality, that there are other factors. And I don't want to lose any African-American children because there's a hands off, you know, we get PC about it. I want to make sure that this is stated so that we can do something about it and that, you know, we know what we can do rather than, you know, if we get caught up in the racism part, that racism causes disproportionality, then we might ignore the fact that there are more black children that die of child abuse, we might ignore the factors that poverty is one, substance abuse, teenage parents.

I don't want to lose what we know causes child deaths, I don't want to lose it in the discussion, and I don't want to be afraid of it. So I want to be able to say that this is a cause but not the only cause, and that's one thing.

The other thing is that I, and many of you know, I went to see the Gentleman's Guide to Love and Murder and you've got to see it because there's an earl, the Earl of D'Ysquith, and the earl has a song that says I just don't understand the poor. And it's a whole song of why would anybody want to be poor and it goes on and on about the conditions of being poor and this earl just doesn't understand it. I don't want to be also be a white person who just doesn't get it; I don't want to be that person either.

So that's all I have to say.

**COMMISSIONER MARTIN:** Thank you.

Commissioner Zimmerman?

**COMMISSIONER ZIMMERMAN:** So poverty doesn't equal violence. I just want to say that. So what you sort of put it all into poverty, domestic violence, all of that. For the last many decades whenever there's a U.S. Census does their polling the two poorest counties in America are both on Indian reservations consistently, decades. So yes, poverty is playing -- there is poverty and then there's profound poverty. And many of our children living on Indian reservations are living in profound poverty. Many are not. So it does play a role.

But I do want to say, Commissioner Bevan, I do believe, I actually do believe, and I don't think it will take away from children, a child of color dying, I do believe that racism actually does play a huge role in the disproportionality conversation in child welfare in this country. And I think that -- again, I think that hopefully we are modeling this conversation that it can be civil, that it can be thoughtful, that we can come to some sort of agreement about it and very explicitly address it in this report.

I think if we try to pretend or we try to minimize it -- it always reminds me when people don't want to talk about racism, it always reminds me of people that really get angry when I want to talk about historical trauma: Can't you all just get over it. And -- or I want to talk about my child's education including tribal history and gosh, we're sick of hearing about Indians all the time. This is from where I'm from. And I have grown up and done twenty years in a system that never addresses tribal history. So when a person of color says I wants to talk about racism in a thoughtful way and have it included in a White House Presidential commission report, I think we need to do that. I think we can't be afraid of it and say, well, let's not make it about racism because we want to make sure children don't die. I think if we don't make it about disproportionality, I think making it about racism isn't going to cause children to die. Because children are being removed at astounding rates that I just talked about in Indian country in particular, astounding rates. Those children are not dying. And often, for Indian children when we do die, they're dying in care, they're dying at the hands of their foster parents, not necessarily their birth parents.

So I guess that's all I want to say.

**COMMISSIONER BEVAN:** Can I just for the record say I didn't say racism doesn't count. I said racism is definitely part of the problem, it's definitely there. I'm not saying racism is not

there. I'm just concerned that if we focus on only racism and not say the other factors -- I didn't say only.

**COMMISSIONER MARTIN:** Let's not be defensive, really, because -- and I think it's a point well taken, it's a point well taken. I don't think we have -- I'm sorry, Commissioner Rubin?

**COMMISSIONER RUBIN:** You can finish.

**COMMISSIONER MARTIN:** I just think it's a point that's well taken and I think it needed to be said and I don't think any one of us is trying to promote that racism is the reason that we have so many problems.

I think a couple of things. I think the panel was excellent yesterday and the work that was done was excellent yesterday. I do think after hearing that and listening to our presentation today, there are a couple of things that we need to also talk about.

One is that I'm concerned that particularly with the minority population -- we have not as a system, system meaning not just the agency but system meaning the court, all the stakeholders -- we have not figured out a good way to include the voice of the youth and the family. We are now looking at families and trying to tell them how to raise their children when they for years have raised their own children. And so I think that we have to talk about really having meaningful ways of including their voice.

I also think that the conversation today in talking about reporting, particularly those anonymous reports, the thing that's important about that in my mind and was very crystal clear this morning is that they're non-punitive. When you get a parent that's having trouble with their child and they walk into my courthouse, the first thing I'm trying to figure out is this serious enough that we're going to start taking her kid, does she really want to be here, because that's what we do. That's how our system is developed. And I'm wondering whether or not we can think of a system, can we envision a system that isn't as punitive but more helpful.

I mean, when you go to an emergency room and you're looking for medical care, very often there are times when the questioning goes around what did you do to the kid but for the most part, they're concerned about fixing the cut, they're concerned about the urgency of that medical emergency as opposed to penalizing or thinking about what happened prior to that. They're trying to help. And I'm wondering do we have a system, do we -- can we envision a system that's designed to help and away from punitive measures.

Let me say just one other thing.

The other thing that I don't think we spent enough time on yesterday is community-based services. In large part, minority communities but black communities in particular rely on community-based services; the church, you know, the youth center around the corner. And I'm wondering whether -- and Mike, I know that money is tight and I know all the restraints and conflicts and difficulties around money but I'm wondering whether there is something about a system -- what would a system look like that really starts relying on community-based services to keep families together. So what would it look like if a mother had a problem with a teenage kid instead of walking into my courthouse where the only thing that's going to happen is we're going to try to figure out is a case, is there a legal petition that we can file to

get this kid into care because that's how we provide services. If I don't have jurisdiction, I can't provide services. The way I get jurisdiction is to take the kids; right?

So what happens if there's a system that doesn't require me to have legal jurisdiction -- let's think out of the box for a minute -- and that we had a way to connect them to a community-based service -- to a church that had family therapy, to a church that had recreational therapy, to a faith-based community that allowed for that parent to get the help that they needed without the threat of taking their child.

So there are a couple of people that have their mics on.

Commissioner Rubin, did you have a comment?

**COMMISSIONER RUBIN:** As I was listening to the discussion of racism yesterday, I'm just continually struck by the fundamental limitation of the child protective service system to adequately address issues because there's almost an institutional racism. It extends on to the mother not being able to get her child back and not because of the circumstances that she's in. And when I look at the African-American death rate, what we're doing is not working; right? And so, you know, from my perspective I think one of the speakers said, you know, our intentions with this family are to mitigate -- the primary responsibility is to mitigate risk and improve the situation the family is and the child protective services is there to address safety; right?

And so that tells me that our way out of an -- our way forward around the issues of institutional racism and disproportionality is that public health collective approach so that whether it's place-based strategies or it's helping those young moms in residential treatment as a priority population, because we know those are the ones that are cycling back into the system with their kids, that we fundamentally change the paradigm and try to make it easier for these families in certain communities, et cetera.

So that's what -- I'm constantly thinking about, well, how do we get some more teeth to the administration's work around place-based strategies, how do we potentially maybe get additional MIECHV funding for those communities that seek to prioritize like if you're working with residential treatment programs you would have add-ons in terms of additional MIECHV funding or if you're connecting it to identified place-based strategies, like it's interlinking these proposals around some of the existing mechanisms and then with the issue of limited funding, which is a reality, Commissioner Petit, I still think the fundamental problem in a lot of communities is that the systems are so siloed that they don't know how to share the money, that in public health there's money Medicaid, there is money -- if we can, knock on wood, get additional appropriations for MIECHV there'll be money in MIECHV.

So I think there are ways we can still operate even in limited funding to really try to direct resources to empower people and I think that at the very worst it's not -- at the very least it's not going to get worse, right, but it may actually get better because you've now had a populational model targeted at specific communities where disproportionality is evident.

**COMMISSIONER MARTIN:** Commissioner Bevan?

**COMMISSIONER BEVAN:** I just want to acknowledge that there are voices in the community here that have been impacted by what we're talking about. And they feel that they have not

had a voice in our commission hearings so there is writing being done right now to put in testimony that I think will support a lot of what was said yesterday but will also make sure that there are no voices left out.

**COMMISSIONER MARTIN:** Commissioner Sanders?

**CHAIRMAN SANDERS:** I would just say technically the -- what we're just talking about now is part of the charge related to title IV and the effectiveness of services. And I think we have to be quite diligent, I believe, in looking at what's been effective, what hasn't been effective, and think through what the implications are and what we might want to do if we wanted to look at more community-based strategies. But that clearly is under IV-B right now and just thinking about how we approach that is going to be important and that was part of the conversation if we talk about CAPTA, we talked about what is the vehicle to actually address some of what's been talked about. Because I don't think we've heard much about effectiveness of family support or even family preservation yet, and so it's something we need to think about.

**COMMISSIONER MARTIN:** Commissioner Petit?

**COMMISSIONER PETIT:** You know, I've had the opportunity over a long period of time to be involved with every one of the states on this topic in some capacity and I can tell you that in every single state, as we have seen in our tours around the country over the last year and a half, in every single state there is excellent, excellent work being done by people who know what it is that they're doing, they're producing great outcomes. The issue all across the country is bringing that to scale. And I don't accept for a second that money is tight, that money's not available, that we don't have the resources. We have by far the biggest economy in the world; we have the money. We are not making decisions as a public that says we want resources spent here instead of there. If you take a look at the per- capita spending on seniors, if you look at the per-capita spending on kids, you look at the per- capita spending on kids in the U.S. versus the per-capita spending in France, Spain, England, anyplace else where we should be ashamed at how weak our investment in children is. And I am very concerned that kids of color especially get the short end of that when you look at where the greatest deprivation is geographically across the country, which states do the least on these kinds of things.

So one of the arguments that -- I don't know how much all of this ultimately relates to child fatalities, I suspect that it does longer term there's some shorter term issues for us, but just think for a moment in terms of the senior and the kid distribution of resources. The states oversee CANF, the states oversee Medicaid. And what you get is wild variations from one state to another in terms of how that's played out.

The two big senior programs are Social Security and Medicare. They are uniform from Maine to Hawaii, from Alaska to Florida. There isn't anybody involved in those programs that would like to see it turned over to the states, no one who receives benefits under those programs that would like to see it turned over to the states. So at some point the resource issue does come up. We haven't talked about it in terms of what's missing on it. We keep seeing what the deficits are in the system and a lot of that is being I think falsely assessed in terms of whether it's -- we think people are racist but it may also be that there isn't enough resources in some

of these programs and that's why there's lousy outcomes. If you don't spend enough, you're not going to get the outcome you want.

**COMMISSIONER MARTIN:** Commissioner Rodriguez?

**COMMISSIONER RODRIGUEZ:** So I absolutely agree about the discussion around community organizations and the shortfalls of what our child protective system can do now and probably what it will ever be able to do to support families. I think people and relationships are who support families. I know for me and my other life at the Youth Law Center one of the things I've been the most struck by in talking to biological parents who had successfully reunified is saying that where their primary source of support was from the foster parent who was caring for the child and how, when they had a supportive foster family who was there who really believed in them, who was coaching them, who actually thought they could be a strong parent, how that made the difference for them. And if the foster family didn't feel that way, how it actually completely interfered with reunification and got in the way of that and how that foster family remained a support system well after reunification, becoming part of the family.

I think that's part of where our bias has been, is to turn to these programs for families and to sort of link them up and think that they're going to be the answer rather than looking at families of -- it just occurred to me that one of the other kind of policy things we could look at that I've been really impressed by is Kevin Candle who does family finding has started actually front ending the family finding that they're doing and so the first time a family has an investigation and a CPS worker goes out, the family finder goes out and does family finding, at that point calls in the family before the case ever even reaches child welfare. Because grandma, auntie, cousins can provide services and support and love and nurturing to a family in a way that a worker will never be able to do, that a home visiting nurse who goes home and is off the clock at 5:00 p.m. will never be able to do. I mean, they have a different vested interest. And it's not true that every family has those resources but for those who do have those resources, that family in place, I think we have an obligation to bring those folks in. And I do think that oftentimes the reason that we don't and we don't consider that is because there is a bias. I think this is particularly true and we have found black and Latino families, we're not as quick to think that the family could actually be a strong and stable support system so black, Latino, and native families, all of the above.

So anyway, I think that it's not just organizations, I think we have to think of a different approach to engaging families, period.

**COMMISSIONER MARTIN:** Commissioner Dreyfus?

**COMMISSIONER DREYFUS:** Just two quick things.

So this commission is looking at its report I believe coming out like in February and right now in Congress, you know, there's two bills that have been introduced now, Bennett and Wyden, on IV-E refinancing, having a lot of impact on IV- B, dealing with what has been this lookback provision that I think quietly as a nation people don't understand it. Since 1996, the federal/state partnership has been radically fractured from that 1996 lookback because every year fewer kids are eligible for IV-E participation so it's been a quiet shift to states and that money comes from somewhere.

So I just want to say on the table here this commission does have a title IV responsibility, but to wait until our report comes out could be too late for us to influence what's going on right now, and that is that everything that this commission is talking about, about front end, greater prevention, stronger, more preventative child welfare system are the things that right now these couple of bills are trying to address. I'm not trying to ask us to be partisan or political. I'm just saying there's a lot of convergence here between everything I've heard this commission talk about for a year and a half and what is starting to be a conversation on the Hill.

The second thing is the Children's Advocacy Center. So I do believe especially, Commissioner Martin, when you talk about what can be going on within communities that doesn't bring in the child welfare system, you know, that creates natural support. I do think there's a larger role that the Children's Advocacy Centers can be playing in communities across the country than they are today. So I'm not saying it's the answer, I think we're all -- like Commissioner Bevan was saying racism isn't the problem but it's a part of, I think we also should not lose sight of what more could be done with Children's Advocacy Centers that communities feel comfortable with that could help increase the safety of children within neighborhoods.

**COMMISSIONER MARTIN:** The last comment will be by Commissioner Zimmerman.

**COMMISSIONER ZIMMERMAN:** I don't have a comment.

**COMMISSIONER MARTIN:** Very well.

Commissioner Petit?

**COMMISSIONER PETIT:** Just in looking at all the recommendations that you distributed this morning and that were discussed yesterday, forgetting for a moment this question that we're all having right now which is ultimately where we need to go in terms of dealing with abuse and neglect generally and ultimately specifically child fatalities, the upstream work, the strengthening families, the building on capacity, et cetera, put that aside for the moment. Just in terms of our principal task of eliminating childhood deaths and that aspect of it that says eliminating them now as much as possible, there's some specific pieces in these recommendations that we should be looking at that address, you know, the immediacy of the issue. We've done some of that with law enforcement, we've done some of that with the incident, you know, response teams, we've been talking about that in certain areas, but I want to make sure that I'm not missing anything in here that rises to the level of this, if it was in place tomorrow, would show a contributing decline in deaths that are disproportionately high among certain groups of children. That's a question. I'm asking if there are pieces here that, you know, that you, Marilyn and others that have been working with this that we can say this is the piece right now that if we were able to put this in place would cause a drop in the disproportionality of children of color being killed.

**COMMISSIONER MARTIN:** Do you have a comment?

**COMMISSIONER PETIT:** I just want to make sure we're not missing it.

**COMMISSIONER ZIMMERMAN:** Yeah, I mean, there's not this baby silver bullet.

I think that one of the things that we have to think about is not to out any child welfare worker but I've been told by child welfare workers working in Indian country because of the lack of resources -- again, I like to use that word "profound" -- the profound lack of resources is that very often they will leave children in potentially unsafe families because there's no alternative. And because the funding -- I have to say it -- everybody wants to sort of not talk about funding for child welfare in this country because it's not a popular thing to talk about but for many jurisdictions, for many rural communities there just -- there has to be an infusion of funding in order to provide services, whether it's prevention services or support services, and they just don't exist. And people are very creative and we have to think about flexibility in funding, not just the funding, but the funding that already exists. I hear about domestic violence shelters that can provide services to the mom but not to the child because the funding source doesn't allow it, that sort of thing.

So for me it's very much about resources for a lot of our families and putting -- keeping kids in risky situations simply because there's no other alternative seems to be an easy answer and let's get them some resources.

**COMMISSIONER MARTIN:** So to answer your question, Commissioner Petit, the one thing I see -- or one of the things that I see listed on the recommendations that were provided yesterday that we could do tomorrow or Tuesday that does and can change how black and minority families are treated and start reducing kids coming into the system and deaths and that is the whole issue about bench cards. The National Council for Juvenile Family Court Judges went in and did a series of trainings on implicit bias. It's not racism. Every one of us has biases. I have biases, you have biases. The issue is understanding our biases and not allowing those biases to bleed into our decisions. And so they developed a series of bench cards that they give to judges.

If we had a similar system that was given to social workers -- my judges come in and talk to me, Pat, listen, today I was able to send two kids home simply because I followed the bench card. And what it does it is it reminds us that we have biases and how to make decisions without including those biases so that we are making decisions that are more blind, if you will. Similar to what's happening in Nassau County and Monroe County here in New York. So that's something that can be done Tuesday in addressing your question to me.

Ladies and gentlemen, I know that our time is short and I'm getting the cane or hook or whatever you call it. I don't know what it is. But I certainly appreciate and thank you for your commitment to this issue. I'm glad that we've started this conversation and realize how important and I'm glad that we've concluded that it's not just racism, that's not what we're talking about. We're talking about something far more important and that is the majority of our black kids dying -- the majority of kids dying in foster care and dying due to abuse and neglect are black and minority kids and we're talking about what we can do specifically to reduce an eliminate that phenomenon. And Mike Petit is correct, this is an issue that has been -- overrepresentation has been talked about since the 90s but I'm glad that we as a commission are recognizing the fact that it's not just blacks that need to talk about it, it's not just Hispanics, it's not a black issue, it's all of our issue. And the fact that, you know, since the 90s we haven't done anything about it but talk about it and we're here to take action and do something about it.

So again, thank you so very much.

**CHAIRMAN SANDERS:** So we have both Commissioner Ayoub and Commissioner Horn on the phone. And I thought I would spend about five or ten minutes just framing kind of my thinking about the final report and also I think making some assertions that I actually think we might have agreement on, and I'll come back to that in a second. But I wanted to kind of just walk through where I see us today and what it is that we need to do as next steps and have some conversation about that and particularly in the context of some of the documents that we have in the binder.

I think first the passion that all of us bring to this I think has been quite evident just in the questions over the last couple of days and our own dialogue and so forth which I think is great and that we have an opportunity, and I heard I think in our very first meeting Commissioner Petit mention it, it's a once-in-a-lifetime or once-in-a-generation opportunity that we've been given by the President and Congress and I think all of us want to get it right, and that seems to be really driving us, which is great. We've had at least -- we've had eleven hearings, research roundtable, dozens of meetings, thousands of pages of research, very compelling written testimony some of which is just outstanding.

So the assertions I want to make are three things and then talk a little about each one of them in more detail.

I think first, and I think there's agreement on this, first our authority comes from Congress and we are -- the authority that we have really is defined in the legislation and we have to continually be careful about both exercising that authority and remaining within the constraints.

I think second we have to fulfill the charge that came from Congress. There are other things that we can do but certainly if our authority came from Congress, we need to fulfill the charge.

And then third, as it relates to a report, that if we -- that it is my belief that individual recommendations are not going to get us where we need to go. As we heard yesterday, there's no silver bullet, there's not a single recommendation that we can make that will completely change it or else I imagine we would have finished our work a long time ago. This really is about the collective set of recommendations that we make and really how we tell a story that actually compels people to act differently than has been the case for the last forty years.

And so having said those two things, and we can certainly talk about if there's disagreement, I just want to go through what our charge from Congress is and where we are on that because I think it helps to frame where we need to go next.

First Congress asked us, directed us to study six areas: The effectiveness of services, the effectiveness of policies and systems, and in particular the most and least effective policies and systems, third is current barriers to preventing fatalities, fourth is predictive factors, fifth is methods of prioritizing services, and finally methods of improving data collection. And then a report that includes recommendations related to reducing child abuse and neglect fatalities including a comprehensive national strategy and second what should be tracked.

I mean, that's the charge that we have from Congress, to study those six areas and to produce a report that includes those recommendations.

If you look at the document that's in the binder that includes the themes and recommendation, I would argue that we've studied those six areas and we have actually a set of themes that fall nicely under each of the areas that we can talk about to document that we've actually studied the areas. So for example, and I don't have to go through all of these, but under effectiveness of the services, we've said under theme one that community partnerships are critical. We've seen it in poor communities, we've talked about those communities, we just finished talking about place-based strategies right now. That's one thing. We've also said with theme two that prevention, up-front prevention is critical.

And so we have examples of at least our thinking and the fact that we studied the effectiveness of services, the effectiveness of policies, certainly those two things, but also the information sharing and -- which is theme eight and how critical information sharing is. And I can and won't do it right now but go through each of the six areas we've been asked to study and we can document that we've studied those six areas and we've included them in our findings which we've had some conversation about.

So the reality is if we wanted -- if all we wanted to do was have a set of recommendation, we could look at what we've already produced, we could put it into a set of recommendations, we could vote yes or no on each of the thirty-four or however many recommendations we have and produce our report. I think what we need to focus on is how we get this message out, what it is that we're trying to convey, and not in a set of recommendations but really in what's going to be compelling to Congress, what's going to be compelling to the administration, what's going to be compelling to people publicly about this issue, which, as Commissioner Petit has pointed out multiple times, we've not seen the kind of action that all of us would like to see.

And so it seems to me that we really do need to focus on kind of what holds this together and how we are able to tell a story, not just produce a set of recommendations. That's why I keep saying I don't think it makes sense for us to go recommendation by recommendation, vote on each one of them. It really is a story that we have to tell. We can go recommendation by recommendation, we could do that now and probably don't need any more meetings. I mean, we could just do that by phone and say yes or no on each of the recommendations. I don't think that's what we want to produce out of here.

So we have -- I would throw out there three or four things and in the document that's staff produced -- I'll ask I think Amy and Hope and Marcy maybe to come up to be available for questions but there's a triangle document that talks about the national strategy that's in there. That was an attempt to address the issue that was raised last meeting about not having just a Christmas tree of recommendations but really looking at what it is collectively that we're trying to accomplish.

And I would just suggest, and I know all of us have opinions on this and so I think this is to at least get some additional thinking out there that we've talked about at least four things that I think are highlights for this, for what we ultimately want to see. One is around the production and analysis of data. I think we've talked about predictive analytics as a tool, so it's just not

the production of data which I think the data subcommittee focused on but how it is analyzed and how is it used to actually make a different system, which I think is the first step in a public health approach which we've talked about.

The second is multidisciplinary case and system-level thinking which is very different than where we've been. We've certainly talked about the CAC's as a model. We've talked about the idea of prospective reviews, a variety of things that move us away from one system being responsible.

Third, we've talked a lot about real time access to data and -- actually, let me go back to the second one.

I think with that second one, and this could be a separate one, but the issue of accountability and the accountability being at a state level, the accountability being at a federal level and not just with the child protection agencies, so the accountability is with the governor, the accountability at the federal level is beyond the Children's Bureau and how do we incorporate that into this multidisciplinary notion.

The third is real time access to data which we've talked a lot about.

And then fourth is that the -- let's focus on who's at risk. And we just had a lengthy conversation about African-American children who are at what, four times the rate of fatality. I suggest that's a population at risk. We've talked about the importance of an intense focus on infants and on young children, a population at risk. And so those kind of themes that are potential areas to think about where we want to go with this.

I think the final thing I would just touch on is that there's been some conversation and that led to the production of several documents that Marcy and Hope and Joanne and Ann - - and Amy all led which was around CAPTA and thinking of if we want to accomplish some of these things, what's the vehicle for doing that and how do we do this in a way that gets us in front of people that compels action. And so that's some of the thinking that's occurred and I don't know, Dr. Horn, if there's anything you'd like to add to that. But that -- where we are today is really how we convey this message, at least that's what I would assert, because we could do a report today that would reflect that we've completed very literally the charge that was provided to us from Congress.

So I'll stop before we have any conversation, see if Dr. Horn, if there's anything you would like to add, and then really open up for questioning to come.

**COMMISSIONER HORN:** Hi, David. Thanks, and I apologize for not being there in the meeting in person yesterday or today.

I must say, David, you expressed my thoughts much more eloquently than I could ever do. I think that -- and my experience is, just to summarize my point of view, is that the most effective reports of this kind are the ones that don't just -- don't see as its goal listing as many possible recommendations as possible but rather to have an overarching sort of message and theme and sort of a standout recommendation that provides an essential organizing principle for the other -- the rest of the recommendations which would I think provide a much clearer sense of what it is that we as a commission think needs to be done.

So I'm very much in support of this notion of getting to a central recommendation, headline recommendation, if you will, that drives the rest of what it is that we as a commission believe needs to be done in order to better protect children from child abuse and neglect fatalities and near fatalities.

**CHAIRMAN SANDERS:** Thank you, commissioner.

Commissioner Rubin?

**COMMISSIONER RUBIN:** I think the vision is there. I mean, I think the idea of increased accountability at the federal level, that's what my last comment I was going to make because I think about the comments you make, Commissioner Petit, first of all, about funds. And I think about Commissioner Horn's prior comments about how we've completely lost sight of children in terms of the accountability structure at the federal government; right? That when we had Deputy Mayor Buery testify yesterday they created a children's cabinet here in New York in response to that child's death, right, and I asked him well, how is that accountability and he goes, because we set priorities and I'm a deputy mayor and that's how we do our budgets, right, why we don't have that on the federal level for children. And the absence of that in a busy universe, it's not that people don't care about children but if they're so far buried in these federal agencies, right, you're not going to see it in the budgets, right, to the same degree. And so there isn't that advocacy and that coordination.

Now, the question is does this -- does elevating CAPTA as the mechanism to do that, is that where we want to go. And I had my team run some data yesterday on Philadelphia -- on Pennsylvania child deaths and I share this as example because I've been chewing on this all -- the last year and a half when we talk about who's known and who's not known to the child welfare system and Commissioner Petit says, well, we know a lot about a lot of those things and we've talked about this many times and I had the ah-ha moment. The average age of death of children who are known to the child welfare system is about a year of age. The average age of death of children who are not known to the child welfare system is about two months. We don't know about them. We may know about their moms, we know about a sibling of them. Because the immediacy, there's no way that child protective services can serve the immediacy of a one month old who's going to die; right? That is a comprehensive public health response that's getting into some of this richer data about mom's history and who responds to that information.

And so when I think about whether CAPTA's the right mechanism, I worry that it forgives in some ways -- it's not the intention but forgives a lot of these other agencies and a lot of these other systems like Medicaid, et cetera, who can send like someone who's just lower on the staff can go join the interagency agreement, there's no teeth to make them realize that the fundamental strategy to mitigating risk in families is a shared effort.

And so how -- to me the vision is that there is some sort of leader for women and children services at the highest cabinet like we've done here in New York City, right, that includes a variety of things. And I'll tell you, they will think about grant making at a larger level to support the delivery of services to women and children, and it includes child protection. But I also don't want us to be so narrow and define this as child abuse and neglect fatalities, right,

when that will lose our partners, because this is a larger issue about the integration of delivery of services to women and children and promoting economic self-sufficiency; right?

And so the last thing I will say is that when I look at the risk of fatalities in the Pennsylvania data, because we've been asking about mental health issues and mom's DHS history, the combination of a mother who has mental health issues and a history of at-home placement of juvenile justice, their children are ten times more likely to die in the Pennsylvania data. What kind of deaths? They're other caused mortality deaths. They're not the deaths that are classified as child abuse and neglect. And that points at a fundamental problem we have is our deaths are so misclassified that just focusing on those that we happen to label child abuse misses the -- and I looked at the diagnosis. Infants dying of gastritis, which is basically reflux, those spitty babies. I've never in my fifteen-year career seen a baby die of reflux; right? Kids with cerebral vascular accidents, those are shaken babies; right? And they're being completely misclassified. And so if we rely on how we report these fatalities to drive and engineer a system -- this is about early childhood mortality. That's why home visiting has been shown to reduce early child mortality because it's neglect and supervision-related deaths that are consequences of poverty, supervision, substance abuse treatment, mental health, and if we want to do something -- I agree with the vision. But if we want to do something that's impactful, it's to elevate women and children services as the national priority because that brings the other partners to the table in a way that they understand and will rally around.

**CHAIRMAN SANDERS:** Commissioner Petit?

**COMMISSIONER PETIT:** Let me just say right from the beginning I think it would be a very big mistake to say women and children's services. If you want to say children's services or family and children's services, but men are so central to this issue and they're not talked about and they need to be talked about in terms of the role they play in this.

The other thing that I would just emphasize is that form follows function again. I don't think we should be trying to decide ourselves on CAPTA versus this versus that versus this versus that. I think the issue is what we want to happen, and there's plenty of smart people in the Congress, there's plenty of smart people in the next administration, they can shape whatever vehicle is necessary once the political process says this is what we want you to do. So I don't think we should start picking and choosing among these small, obscure programs, which is what they are in child welfare, and return to Congress and the White House to deliver the goods. They'll deliver the goods if they think this is important. They have complete capacity to generate whatever they want in terms of how the federal government conducts its business.

**CHAIRMAN SANDERS:** Commissioner Dreyfus?

**COMMISSIONER DREYFUS:** So when I think about what we've been doing over a year and a half, it does seem to me, and I think Chairman Sanders laid out some of these areas of focus we've had, you know, community partnerships, how key they are, prevention, information sharing, data analytics, real time access, a different accountability cross-sector, a different focus on who is at risk. And I know that I've used this phrase a lot because I really have come to this in just my own experience and that is that we're using a twentieth century version of

child protective services in what I think is now a twenty-first century world and I think this commission has been putting more definitive descriptions for what that needs to be.

I don't look at the use of CAPTA in terms of it changing CAPTA. I look at us saying it has to be completely re-envisioned. I look at a recreation on what is now an outdated, outmoded mechanism that needs to be completely re-envisioned in all the ways that we are talking about. So -- and it's time for us, I think, to challenge, and I don't agree that Congress and the President are going to figure it out. I think we have a responsibility to talk about what might be that vehicle and mechanism for doing this is Commissioner Rubin, for what they're doing in the City of New York where the mayor has said you are all -- like Governor Gregoire when she put together a subcabinet would look at us all and say you are all accountable for re-envisioning our welfare to work system, community college system, blah, blah, blah, blah, early childhood, the whole thing; right? Something has got to start modeling this at a federal level.

And if we keep being hammered down by, well, the committees of jurisdiction or, well -- we've got to start thinking I think in a more omnibus way about saying to the federal government we can't be saying like place-based work, it's about integration, it's about cross-systems sharing accountability, sharing responsibility, thinking and acting together. Well, somehow it's got to roll up to then what's got to get hard wired into the federal government that creates a different way of governance is happening, accountability is happening at the federal level.

So I just think that to me this idea of CAPTA wasn't just about adding a few more bells and whistles to CAPTA, it was about a complete re-envisioning, recreation of CAPTA and saying that what it was then is not what it needs to be going forward and this is how it needs to be recreated.

So that was just how I saw this. If we're going to get hamstrung by, well, we can't do that because it's across -- it cuts across different communities of jurisdiction, it's like well, then why not just make our thirty-six recommendations and all vote on them because we're not going to get the kind of cross-system integrated approaches we've been talking about for a year and a half if we're hamstrung by that outmoded mechanism.

**AMY TEMPLEMAN:** Chairman Sanders, I'm noticing that the commissioners have different documents in front of them right now, so I'm wondering if you'd like us to choose one of the documents and maybe provide more information about how it came together.

**CHAIRMAN SANDERS:** I would certainly yield to the will of the commissioners. I think part of the question is do we want to start with where we are in terms of recommendations, go through them one by one vote on them, and say we've completed our tasks or are we looking to try and tell a different story that will compel change in a different way. Because I think that's a basic question that gets at some of the questions about process and what we want to do next, so I want to make sure there's clarity about that. And then we may want to look at kind of document by document what we've talked about. We could go through the recommendations and just vote on them.

**COMMISSIONER HORN:** David, this is Wade. It's hard for me to virtually raise my hand, so I apologize for jumping in.

I just want to really emphasize and associate myself with the remarks that Susan just made. This whole notion of focusing on CAPTA was not because we think or I think that if we just gave more money in to CAPTA all would be right with the world. The notion of focusing on CAPTA is that it is the one piece of federal legislation that is specifically targeted towards trying to protect children from child abuse and neglect, but it is flawed. And in my experience, the way that you can transform systems is you have to do it by putting additional and significant additional more resources into it. So this is not just about picking out a particular program and just putting some more money on it and saying we're done. It really is -- the idea here, at least to my mind, the idea here is to use this as an opportunity to fundamentally transform the system but you need something to do that a with. And if you just sprinkle a little bit of money here, a little bit of money more there and so forth, it's not going to transform the system. And so the significant resource increase in CAPTA would be conditioned upon states doing things dramatically differently than they do today and the federal government under the way that CAPTA's currently being administered and implemented.

So I apologize for not making that point earlier but I think Susan is exactly correct that this is not about just, you know, putting some more fuel in a ship that is sinking but fundamentally transforming it but you need a vehicle to do that.

And now again, we can just go through every one individual recommendation and we can just vote on them and fine with me if that's what we choose to do. I just think that if we're going to make a real impact there's going to be a central organizing principle, a central organizing recommendation that makes people sit up and take notice and also something that sounds doable and achievable.

So that's my point of view.

**CHAIRMAN SANDERS:** Commissioner Petit?

**COMMISSIONER PETIT:** Yeah, I mentioned CAPTA a few speakers ago. And I was not minimizing CAPTA. I just didn't want to be thought of as the administrative vehicle somehow that runs itself. I think what Susan's stated is exactly right and I endorse completely what Wade just said in terms of supporting that. So I think we're on the same wavelength. I raised CAPTA as let's not bury this within the middle or lower levels of the federal bureaucracy, it needs to elevate to the top. So CAPTA could be a perfectly good funding vehicle. What I was expressing is whatever advice we give on structure, once people embrace the idea that we need to exactly what we're saying, transforming the system -- states, federal, et cetera -- a vehicle for administering it will emerge. So we don't have to have it down precisely was my only point on that.

**CHAIRMAN SANDERS:** Any other comments or do we want to hear about CAPTA? Yes, Commissioner Rubin?

**COMMISSIONER RUBIN:** Yes, I just wanted to say, Commissioner Horn, I kind of assumed that's what you were thinking, like I think that you were -- that I assumed -- and I'm not against CAPTA per se. I want to be convinced how we can make this widen the lens. If it's CAPTA as a vehicle that low-hanging fruit to do that, great. By its very name I worry that it sort of becomes very sort of issue-driven as opposed to really what the larger systematic issues are.

But that doesn't preclude us from thinking creatively, yeah, here's this vehicle, it already exists in the federal structure and so we could -- rather than reinventing it completely starting from scratch. I just want to be convinced how we could use that kind of legislation to do that because I understand the nature of what you were trying to do and the vision was there.

**CHAIRMAN SANDERS:** It seems like there are several options. One is there's IV-E, there's IV-B, there's MIECHV, there are a variety of other options. It seems -- that's one. It seems that a second is there any ability or potential for a new piece of legislation that -- but it would mean -- but CAPTA has to then go away. It can't be you keep CAPTA and do something new given the structure that's really defined within CAPTA or is there -- or are we not wanting to think of a vehicle. I mean, so -- and we don't -- I don't know that we need to define that exactly today, I think we'd want to look at options, but it does seem that we need to think about are we looking at some vehicle to kind of completely change what's happened historically and define more consistently with some of the things that we've talked about today or again we can look at kind of piece by piece and recommendation by recommendation.

Commissioner Martin?

**COMMISSIONER MARTIN:** So I was explaining to my niece why I was here and I was trying to explain to her that within the federal government issues that deal with children and their safety and families are in different cabinets and under different responsibilities; the responsibility is spread throughout the federal government. And so her question to me was kind of an uh-duh. Well, Aunt Pat, why can't you guys put everything that deals with kids and safety in one cabinet, in one place in the federal government so that you don't have to worry about people to have an understanding of what's happening in one cabinet versus another, you don't have to share information because it's all right there, and that the people who know the most about kids and their safety are all in one place.

So my question to us is why don't we think about something as simple as that? Rather than CAPTA not being vast enough to handle a total re-haul, and we've talked about elevating the importance of children and safety to a cabinet-level position where we report right to the President and get an annual report to Congress, what precludes us -- I mean, there are a multitude -- we can start listing them on one hand, you know, or two hands all the reasons why it would kill Congress to do something like that but what precludes us from making -- does that make sense and if it makes sense, why aren't we recommending something like that?

**CHAIRMAN SANDERS:** Commissioner Cramer?

**COMMISSIONER CRAMER:** Where to start here.

When I was a member, we stood up as much from an incredible reaction to 9/11, a director of national intelligence. And I remember the intelligence committee debating whether we needed more or less an intelligence czar and whether we needed to force the DOD community, the CIA, the various NROs, the three-letter agencies to all come together. And we debated it and we struggled with it, not to make you hear too much background. A lot of us said it makes so much sense to do this, to have one sort of place to go that they all had to

report to but it hasn't worked very well at all. And we did a version of that with Homeland Security when we set up a new agency there and that, I'll say on the record, has been a complete nightmare and a bureaucracy that never got really started. Once it did get started, it was just everybody's worst fear.

So I'm just urging caution. I'm not saying don't do it, I'm not saying do it. I'm just saying be careful --

**COMMISSIONER MARTIN:** What you wish for.

**COMMISSIONER CRAMER:** Yeah, and what controls you have and whether you're, in fact, just establishing another level of bureaucracy.

**COMMISSIONER BEVAN:** I agree.

**COMMISSIONER CRAMER:** Still, the issues we're coping with, the recommendations that we've looked at, reviewed, are considering the last year and a half of our existence kind of go to the heart of this as well. The question to me becomes is CAPTA the vehicle, is child safety czar the way to go. I don't know.

**CHAIRMAN SANDERS:** Commissioner Bevan, Dreyfus, and Rubin.

**COMMISSIONER BEVAN:** I associate myself with the remarks of Congressman Cramer.

If we're looking for a recommendation headline I think it has to be child safety, it has to be about children, and to say -- our job is not to give the answers. Our job was to raise the right questions and to say these are the right questions and the answers to these questions will reduce child fatalities.

We are not charged with coming up with the answer, we're charged with developing the right questions. And so under the framework of accountability, oh, yeah, there isn't a lot. Collaboration, no, there isn't a lot. Duplication, yes, there is a lot. We need to -- I think we need to frame our recommendations in a way that's actionable, in a way that somebody can take it and do something with it. If we tell them what the answer is, correct me if I'm wrong, but Congress has not responded well to commissions or to anyone else telling them how to work; right?

**CHAIRMAN SANDERS:** Commissioner Dreyfus?

**COMMISSIONER DREYFUS:** So Commissioner Martin, to the question you put on the table, I envision that we could be looking at the elevation of the Children's Bureau, something that Commissioner Horn has talked about and recommended that, as part complete of this re-envisioning of again a complete recreation of CAPTA, that the elevation of the Children's Bureau in terms of connection to the President would be something I think we've talked about and could potentially consider.

I think the problem you've got is when you go to this one place, the bottom line is the Department of Education will always be key to this issue, the Department of Justice will always be important to this issue, but I do think when there is the elevation of the Children's - - if it is the Children's Bureau, if that's what this commission decides to do, then having something that makes it clear that that person's ability just like Deputy Mayor Buery has the

authority, right, to convene people and on behalf of the -- it's kind of like I think about Roy Austin, right, and his position and has the authority to convene people and hold different agencies accountable for their work, I think that's probably closer to where we would get than it's all just going to be in one place.

**CHAIRMAN SANDERS:** Commissioner Rubin?

**COMMISSIONER RUBIN:** I was looking back to you, Commissioner Cramer, and you, Commissioner Bevan, because I thank you for saying that in terms of the bureaucracy can sometimes get from going too big.

But are there precedents to do just what Commissioner Dreyfus talked about? Is it domestic policy? Are there examples that you guys have seen, you know, on the executive branch or on the executive side that have accomplished that sort of level of accountability, direct access to the President in terms of priority just like we had this committee here that hasn't created a new department but has created that authority and this interagency real accountability and coordination?

**COMMISSIONER CRAMER:** I don't know.

I do feel like I need to add when I was struggling as a prosecutor with my role with taking a child to court and that narrow sort of legal criminal justice system vision of that and then the more I got experience with my social workers, the more with law enforcement, the more with mental health, medical community and all of that, I wanted this one-stop center. Much like your niece, I had a grandmother who's just made an incredibly significant contribution to my local children's advocacy center, she was -- her granddaughter had told her this horrible story of abuse. And so I was telling her about this one-stop center that we were going to start or it was our idea, we weren't sure we could do it at the time but we ended up doing it, and she said what would take so long? This is not rocket science and this should be easy to do. And then when I was knocking on doors with funding sources in D.C.

and I'd go to the Children's Bureau and I would go to Justice and I would go to the National DAs Association, the relevant county commission organizations and sort of thing, it struck me that the agencies needed a one-stop service center. So here I am coming full circle to say if there's some way we can do this.

And the problem with the DNI is that what happened with CIA, what happened with DOD and NRO and the various intelligence agencies are doing very specialized things but often overlapping with what they do is the leadership just kind of surrendered a bit because they said well, now, we've got this new DNI here. And often if we would hold these hearings and we thought it would make our jobs easier to kind of call the DNI over and say in terms of counterterrorism, in terms of satellite structure for us gathering intelligence and information, what are we spending on it and all that, it didn't streamline anything. In fact, we would find out that the CIA was resisting everything that the DNI said.

So David, I don't know if there's a model that we could use. It does occur to me that the recommendations we make would have to cause us to look at a recommendation that would say we want to streamline this sort of clearinghouse of the way money's spent, that sort of thing.

**COMMISSIONER RUBIN:** I want to make sure I also address that question to Commissioner Horn because you served in the administration as well, too, so your thought about have you seen precedence of how this could work at the largest level.

**COMMISSIONER PETIT:** David, I mean the question -- this one could go on indefinitely, this question we're having now, and I'm sure we're going to circle back on it and I don't think we're ready to draw any conclusions on it yet.

I would note somebody raised it last time and I put in a plug for the notion of revising -- not revising, recreating the White House Council on Children, Youth and Families. When you look at the two-pronged approach we've been taking is this one of immediate what can you do right now to save this kid right now and then this other one that talks about a public health model and an upstream standing and so forth. And the White House conference, the last one was held in 1970 and it would be a way of focusing attention on the needs of children and gets us into the morbidity issues which is how you address the mortality issues. But that is the aside.

The question I have now, David, is how are we going to go about the next week, month, twenty minutes, the next two months in terms of actually coming to a conclusion about what this document is, the graphics, the charts, the actually loading on recommendations? I mean, rather than try and go through those recommendations right now, can we just spend a few minutes on what the process is everybody is going to lock into on this?

**CHAIRMAN SANDERS:** And that's why -- I'm going to make a presumption that we -- because as I said, we could vote on the set of recommendations we have right now. And I'm assuming that's not where we want to go. But if that's the case then that should be our next step.

**COMMISSIONER PETIT:** Absent that, what is the next step?

**CHAIRMAN SANDERS:** I want to make sure that it is absent that. Because it seems like the question of kind of how detailed we want to get about the kind of individual recommendations versus overarching themes.

**COMMISSIONER DREYFUS:** So how do you want us to share that? Do you want to go around the table? What do you want to do?

**CHAIRMAN SANDERS:** Sure, that would be great.

**COMMISSIONER RUBIN:** Should we also ask the staff? Have they thought about this? I mean, they've obviously been doing some work but just figuring out what they've been thinking about.

**CHAIRMAN SANDERS:** Amy?

**AMY TEMPLEMAN:** How we've been thinking about a national strategy?

**COMMISSIONER RUBIN:** Well, it sounds like the larger question is how are we going to move forward and get to those recommendations. We started to --

**COMMISSIONER DREYFUS:** No, that's not it.

**COMMISSIONER RUBIN:** About this?

**CHAIRMAN SANDERS:** I'll address that. But I think the question about do we go through the recommendations now just as a set of recommendations, vote on them, we've completed our task from that perspective, or do we actually put this together in a way that tells a story.

**COMMISSIONER PETIT:** And we have to discuss what the latter would mean so that we could weigh it against the first choice; right? So what are we talking about?

**CHAIRMAN SANDERS:** Commissioner Martin?

**COMMISSIONER MARTIN:** So I feel somewhat intimidated that Rubin said uh-oh when I turned on my mic.

But anyway, aside from that, you know, I personally am not ready to vote on the recommendations because I don't think we've made any. All I mean, we have in front of us, right, all we have in front of us are the recommendations we've heard from experts and, not to minimize it but the tremendous work that staff has done we ourselves as a collective haven't made one recommendation yet.

**CHAIRMAN SANDERS:** We have subcommittee recommendations that we could put in front of us and say are these recommendations we want to support as a full commission moving forward or do we feel like there is more conversation about how we do this, what the central theme is, those kinds of things. Because we do have a number of subcommittee recommendations that we could just put before people and say let's vote.

**COMMISSIONER MARTIN:** Well my preference, Pat Martin's preference would be that we have a further conversation about where there's a central kind of what did you call it, a central theme or a --

**COMMISSIONER BEVAN:** Organizing principles?

**COMMISSIONER MARTIN:** And then kind of fill, like backfill that in. I personally don't think that I want to sit here and vote on individual recommendations.

**COMMISSIONER BEVAN:** I think that we haven't developed an organizing principle. And I know when we do legislation, you need to have the organizing principles in place. We need to be able to say child safety first and whatever else we think has to come second, third, and fourth. But we need to develop some organizing principles so we know where we're negotiating, what are we negotiating. I mean, if it violates our principles, three of them or whatever it was we agreed to, if it supports our principles we go with it. If it violated the principles then you don't go with it. But we need something beyond these themes to pull us together.

**CHAIRMAN SANDERS:** So that's -- the proposed national strategy document is intended to reflect the themes and that's something that we just got today.

So if there's -- if we are set that at least we're not ready yet to vote in the individual recommendations then I have a proposal for how to move forward but I want to make sure that we're ready for that, and I don't see any -- so one, we've put together some ideas with staff on the national strategy. And it's consistent with the four things that I talked about. I mean, there are three in the national strategy; there's enough overlap.

I think we just begin to write based on that so that by one or two phone calls from now we actually have a document sitting in front of us that's consistent with the national strategy that's been laid out. You have a first chapter in front of you that will require some revising because it was done before the national strategy document. We use that national strategy document to kind of drive the writing. We also have the story. We have the outline of chapters that is being proposed that was really based again on that national strategy.

So there's some things in front of you that can be reviewed but basically that we would just start based on the documents that are in there right now.

**COMMISSIONER BEVAN:** I don't want to start with the documents that are in here right now because we don't have child safety as first. We've got child safety as like the fourth thing on here.

**CHAIRMAN SANDERS:** Well, we could talk about what those are.

**COMMISSIONER BEVAN:** I mean, I have a real problem with this is the way we approach it.

**COMMISSIONER RUBIN:** I would propose this issue of the backbone be the next discussion like and then backfill from there going through our recommendation because I think that larger overriding theme is going to be key to making this not seem like a set of recommendations. And for me I think federal reorganization is part of it, right, what we were talking about this morning.

But I have this vision that if we are successful how would the world change? Well, we would have many more communities like New York that have a committee with the highest levels with accountability to the mayor or to the governor at the state level that were organizing a more line delivery system for families that includes child protection -- enhancements in child protection services and the question is well -- and that the states would be required -- the states and communities as it trickles down would be required to explain and submit plans for how they accomplish that.

Now, the question's how do you do that. That involves, we believe, that in order to accomplish that the states will need a federal reorganization to align budgets and grant making that will permit the state to have the resources sufficient to accomplish that mission; right? We believe that the states -- like so we can -- but I actually have sort of always felt the backbone was about achieving that vision of a higher level of accountability at our local communities and our states and then what we believe it will take to get there is -- sort of wraps in around then that's where that federal reorganization. Because that's not going to happen unless really our agencies get together to really think how to align their grant making across Medicaid and everything else like that to permit a state to reinvest their resources or et cetera.

So that's how I see the backbone but I'm actually thinking this is a great time for us to discuss how other people see the backbone of this recommendation.

**CHAIRMAN SANDERS:** Commissioner Rodriguez and Dreyfus?

**COMMISSIONER RODRIGUEZ:** So I just want to make sure that everybody is talking about the same document. Because I hear everything that everybody is saying, I see it reflected in this

overall document. The leadership and accountability is sort of the high level, the measurement data and data, advancing the safety, the integrating the systems, breaking the cycle. I mean, to me this feels like the framework that we've all talked about.

And it may be that I'm not fabulous with process but I feel like this does give us sort of a framework that between now and the next meeting we could see this and the following two pages that is worth writing on so that we actually have something to substantively react to and to see whether we feel -- when you look at all of the components that are in the three pages though, it does feel like it's capturing everything that people are saying they felt like sort of the vision should be. I'm not hearing any disagreement actually when folks are saying what they really want to see. It seems like it's reflected in this.

**CHAIRMAN SANDERS:** That was the goal.

**COMMISSIONER DREYFUS:** I want to just absolutely -- Commissioner Bevan, I want to ask you because I think you're raising a really good point about the themes, what was the term you used, the overarching principles or something; right? Was that what you used?

**COMMISSIONER BEVAN:** Organizing.

**COMMISSIONER DREYFUS:** Organizing principles.

Forget the narrative that's here right now as just a draft cut but go to this chart, the chart, because I want to agree with Commissioner Rodriguez. It seems to me that those organizing principles are sitting right here; that if we're going to prevent child abuse and neglect fatalities and fatalities as a country, there are three integrating factors that are critical to that and there are two bookends; right?

**COMMISSIONER RODRIGUEZ:** There's a roof and a foundation.

**COMMISSIONER DREYFUS:** There's three concurrent integrating pieces: Safety, stronger CPS agencies, integrating systems, selective responsibility for action, breaking to cycle which to me was all about consistency, forward-leaning continuous quality improvement, the best use of our data, right, and then these two bookends, leadership and accountability. And Commissioner Rubin, that's federal, that's state, that's local, that's not just child protection, right, but leadership and accountability. It has to happen at the federal level and the state level. And then measurement data and research that's critical underpinning, right, of this as well.

So I guess I'm just asking my fellow commissioners, I saw this -- forget the narrative stuff that's here, whether we like that or not, I just saw this as a beautiful recap of the organizing principles that our report and our recommendations could be framed around. So I just wanted to hear if Commissioner Bevan thought that as well or that wasn't quite what you were still thinking.

**CHAIRMAN SANDERS:** Commissioner Bevan?

**COMMISSIONER BEVAN:** I just want to say, so I don't see it because advancing safety, stronger CPS agencies is not what we talked about. We've talked about multidisciplinary all along.

We've never said only CPS. We've said law enforcement, medicine. I mean, we've said all of this before.

**CHAIRMAN SANDERS:** Actually, we said both because the whole CPS subcommittee included a number of recommendations that were really specific to the CPS agency.

**COMMISSIONER BEVAN:** But I thought this wasn't about the recommendations from subcommittee.

**COMMISSIONER PETIT:** That's true. But the CPS piece is so large a force in the total resources that are committed to this thing and it plays out at thirty-three hundred offices right now and there's a whole body and network of law and state legislative committees and everything else, it deserves I think special emphasized attention.

**CHAIRMAN SANDERS:** Commissioner Rubin?

**COMMISSIONER RUBIN:** I think if this is the framework we're going to use as a logic model, first of all, safety science and systems analysis I really believe falls under advancing safety. That doesn't break the cycle. What breaks the cycle is intergenerational health approaches, approaches to neglected communities; right? That's how you break the cycle; right? And so I want to -- just for the record, I don't know if everyone agrees with me on that. That's where intergenerational health and where place-based strategies go.

**CHAIRMAN SANDERS:** So let me step back then and suggest that then it sounds like a document like this is where we shall spend our next few hours going over verses, actually producing something that hopefully captures what we're talking about. So we would start with this as the next step and then move to agreement or a vote on this kind of high level framework and then we will write out of that conversation.

**COMMISSIONER HORN:** Commissioner Sanders?

**CHAIRMAN SANDERS:** Commissioner Wade.

**COMMISSIONER WADE:** So first of all, I want to say that Commissioner Bevan, that I completely agree that there needs to be a statement of principles up front. I completely agree with her that one of those principles if not the number one principle is really about child safety. It doesn't mean there can't be other principles as well.

And again, I just want to clarify that at least in my mind when we talk about -- if we were to see CAPTA as the vehicle for transforming the system, all of the other things that Commissioner Bevan was talking about that this is more than just the CPS worker, it's also about the law enforcement, it's also about broad based -- greater involvement of the mental health and health community, all of that I would envision would be part of and central to, in fact completely dependent upon an infusion, a large infusion of additional resources through a specific vehicle that is charged with -- in a way that title IV-E is not charged with, for example, protecting children from abuse and neglect outside of the foster care system.

And so I don't want to rush this though, so Commissioner Sanders, I feel -- I'm not in the room so it's really hard because I'm only listening to voices, but if I'm sensing this correctly I feel like this is one idea that has been put on the table, I happen to like it but it doesn't mean it's

the right idea or the only idea. I would urge that we understand that this is exactly that, one idea and not rush too quickly to a vote on this at all but rather let's have the discussion today but then let's also have people kind of think about it and maybe the staff could make changes to it -- not maybe, they should base upon what they hear in the conversation today, have another -- I think your next meeting or on conference calls and have those to get some additional reaction and perhaps put additional ideas on the table. So I don't want this to feel like -- I feel a little bit like it's getting a little rushed and I think we clearly need to address everybody's concerns.

**CHAIRMAN SANDERS:** Commissioner Petit?

**COMMISSIONER PETIT:** I want to go back to the point that was just raised with the CPS agency and safety. We all receive -- I think we all receive these daily notes or headlines that Tom Morton sends us that talk about the chaos and crisis that exists in child welfare, child protection all across the country. There are numerous states that are cited, there are state legislative investigations, there are attorney general's investigations, there are governor's investigations, there are newspaper investigations, every day in/day out. And what we keep seeing are these same themes about the agency is not equipped to do what it is charged with doing, they have too many cases, they don't have enough workers, they don't have enough experience, they don't have enough collaboration with local law -- whatever it is, they are in a -- many of them, in a crisis mode. I don't think that they are at this point at the same level as some other issues. They really need attention from us on this piece. We've gotten recommendations from NAPCWA, the National Association of Public Child Welfare Administrators. I haven't read those yet. I don't know how specifically they speak to this. We haven't talked about the dollar resources that are needed to go into this thing.

But in the short term, say the next three years, we're not going to see much change except beefing up the ability of CPS current mode working with others to intervene on behalf of these kids. All the sub stream stuff that we're talking about, all the intergenerational health, all that, that's all good. It's a longer term kind of a thing. I don't believe it is going to address the immediate issue that CPS is facing right now, and that really deserves special discussion about law, data, resources for the public child welfare agencies and who they work with in the states.

There's an apparatus already set up, there are state legislative committees that deal with this thing, it's a well-established vehicle, so the question is how much does it need to get charged up, if at all. If people think it doesn't need to get charged up and we're going to do something else, I'd like to hear it. In the meantime, short term sense of urgency, we need to beef up the states' capabilities in the thirty- three hundred offices or so where they have to do child protection business across the country.

**CHAIRMAN SANDERS:** Commissioner Martin?

**COMMISSIONER MARTIN:** So I don't think I disagree with Commissioner Petit. I'm not sure that I put as much emphasis on beefing up CPS workforce as he does though. Because no matter how we increase the workforce -- we can have one worker per family. If we don't look at the effectiveness of the services and service delivery, it's for naught anyway. So I think the recommendation about beefing up CPS' workforce with training and numbers is great but that

in and of itself is my point, it does not necessarily affect safety until we talk about the ability to train, make certain the training is more diverse, make certain that the services are more effective, the services actually deal with the issues that the families are having. In my opinion, just putting more money and more workers isn't the answer.

**COMMISSIONER PETIT:** We completely agree on that. That's not what I'm suggesting. I'm suggesting that the states have vehicles right now, they have training apparatus, they produce documents, they have relationships with media. I mean, they are central at this point to this issue and we're talking about beefing up other things and introducing other things. But the CPS, they are out there right now under fire every day and it's not being staffed up or otherwise able to deal with this issue.

So when I heard Cassie just say -- well, we need to do the public safety and we need to do the other. We need to do both in terms -- but in terms of the urgency question, rallying the American public, getting our next president to talk about it, getting congressional committee to hear about it, there needs to be some direct urgency that says how we address the CPS crisis and that's what it is across the country right now.

**CHAIRMAN SANDERS:** Commissioner Rubin and Commissioner Rodriguez?

**COMMISSIONER RUBIN:** Yeah, I just want to, you know, I don't want our deliberations to be a trade-off between intergenerational health and CPS and that's not our job. I will say, as someone who spends a lot of time in healthcare around the ACA, there is a policy window right now between MIECHV, Medicaid, ACA, all the work around the investments in healthcare and the reorganization and payment reform in healthcare that it would be foolish of us -- I think the opportunities are not downstream; they're right now. And, you know, we have an opportunity to align those resources towards the families that we work with in a much more intentional way and that's what's not happening. And so I do think that there are immediate opportunities in intergenerational health.

**CHAIRMAN SANDERS:** Commissioner Rodriguez?

**COMMISSIONER RODRIGUEZ:** Well, I was just wondering if getting rid of the sort of subcategories and keeping the general principles for each one of these that our focus is we have the roof, the overarching leadership and capabilities, the bottom line being that we want to move to a system that has a foundation of measurement and data and research and that the three areas that we're seeing are breaking the cycle regardless of whether that is an intergenerational health approach, a community organizing, and working with families in a more respectful and empowering way, advancing safety and that could be talking about how we better use the safety science, how you strengthen all of the agencies that have a role in child protection, and then integrating systems; whether if you eliminate sort of the subcategories on each of those, do those resonate with people. Because that's what resonated with me, was hearing I did feel the advancing safety, integrated systems, and breaking the cycle to me with sort of the overarching leadership and the bottom line of now we're really going to run a system as opposed to what you said earlier, having a bunch of freelancers. I felt like that, that did it for me. Or do people really even uncomfortable with those categories.

**CHAIRMAN SANDERS:** Commissioner Rubin?

**COMMISSIONER RUBIN:** Yeah, I was going to say I actually think we can work with this. But I see this as the logic model below that step that Cassie talked about because it's still jargoning; right? And so what I'm thinking is we need that headline, that's what I've heard Commissioner Horn say, Commissioner Bevan, we need that headline that organizes this. And I always think of that as the vision, what we're trying to achieve. But I think we're at the two level when we're still also at the one level; what are we trying to achieve.

**COMMISSIONER RODRIGUEZ:** Can you explain to me though the headline? Because I felt like that was the jargony piece of it, how you message it out to the world. But I'm not a marketing personnel.

Can you explain, when you all are talking about a headline, what does that mean?

**COMMISSIONER RUBIN:** You tell me, does this that kind of chart do it for you or are you thinking more systematically?

**COMMISSIONER BEVAN:** I wasn't thinking of this as marketing, I was thinking of this as this as what the commission is about which is child safety. So I think the headline has to be that we're not doing it right in terms of -- in terms of child fatalities, we have too many and we seem to be doing too much and too little at the same time, we've got duplication and then we have not enough of some things, too much of another, overlap, and people falling all over each other which we've had at almost every hearing people say that there's not, you know, the data's here or the data's, you know, and one hand doesn't know what the other hand is doing, somehow capturing that. Because we also need to say in some sort of headline that the message is we can do better, we will do better, but that this is an urgent message of kids are dying and that we have to get some attention to because no one's paying attention to it and they won't unless we have something like this.

**COMMISSIONER RODRIGUEZ:** I still don't think I understand.

Can somebody give me an example of a headline from another --

**COMMISSIONER PETIT:** I can give one on this. Child protection in crisis. National commission proposes overhaul, something like --

**COMMISSIONER RODRIGUEZ:** That is marketing though.

What I'm trying to understand is that sounds like you're messaging, you're external messaging to the world.

Is that what people are proposing have settled first or is it more like a value or organizing principle? I'm just not understanding what it is that we're trying to get as a first step.

**COMMISSIONER HORN:** I'll give you an example.

So I was on the National Commission on Children which is probably, in my view, and it's sort of due to the hard work of not just the commissioners of which I was one but the staff as well, by almost any measure that I can think of was successful and that about ninety-nine percent of all of its recommendations were eventually implemented. But the big headline recommendation was we have to support families and children better. And the central recommendation, and this is a bipartisan commission led by Jay Rockefeller, was a thousand

dollar refundable tax credit for every child in America. That was a -- and you know what? That came to pass. That was a very bold recommendation. So there was lots of other stuff, too, that was in there. There's chapters on state healthcare reform -- I mean, healthcare reform, other stuff around child care, there was some stuff on child welfare, but that was the big sort of bold recommendation.

**COMMISSIONER RODRIGUEZ:** So that is really helpful.

This discussion is really about then developing what the big overarching recommendation that all of the other recommendations will fall under; is that -- do I have that now correct? Am I understanding?

**COMMISSIONER HORN:** Yes. That would be my suggestion. It certainly is not the only suggestion, it may be the wrong suggestion, but that's my feeling.

**CHAIRMAN SANDERS:** Commissioner Zimmerman?

**COMMISSIONER ZIMMERMAN:** So just for clarification, so the overriding then would be so you're saying it's got to be about safety, safety, safety, safety; right? So the overarching is the safety of the children, is that -- and then all of that would just fall under that.

**COMMISSIONER CRAMER:** Couldn't it also have something like failed system, children failed to --

**COMMISSIONER PETIT:** I think that the child safety issue is the strongest from the press and public and lawmakers' point of view. The public safety issue everybody gets, nobody wants a kid killed, that part of it's not -- is not controversial. The suggestion that I made that says child protection in crisis national commission proposes overhaul, that does speak to the systemic breakdown on this and what needs to happen and it includes those themes, but it can go back.

And then once we get the public's attention, all the other stuff that's soft or that isn't as grabby gets discussed.

But just think of this. We've been convening for about five hundred days. During that period convening hundred kids have died. It's going to be another two hundred days before we're done, another fourteen hundred kids are going to have died. We have got to propose some stuff that says this is an intervention right now that's meant to address the deaths of these kids through the pipeline right now, and I think that's a public safety issue.

That it turn -- we know -- when anybody mentions to me, just a citizen or family member, child protection, they read about these horrible deaths, their first response is always the same: Throw the parents off the Washington Monument. They are so angry at the parents on this thing and they have a hard time going beyond it. Once you start talking about exactly what underlies all this, they start to develop a greater opening -- I mean a greater understanding, they start to open up, and they say okay, it's more complicated than I thought, we need to do a number of things on this thing. I think that's what we're going to be eventually saying is that you've got to do a lot of different things, but what's going to be the headline grabber that focuses attention. I don't think it's going to be a soft thing that says let's help children and families. That's not going to be a strong headline that the press is going

to pick up. If a national commission says this system is in crisis, we need to get on it right now, there's thousands of children dying, I think that's what they're going to pick up on.

**COMMISSIONER HORN:** If I could just add, I totally agree with that one thousand percent. And I would expand that I think you've got to quickly follow it up with a very clear and dramatic recommendation. Which you can pick your number but my favorite would be -- my suggestion would be -- and in order to achieve that, the first thing that needs to be done is an infusion of resources, pick your number, a billion dollars, raise capital funding to a billion dollars a year and use those funds to transform the system so fewer children die. That works for me.

**CHAIRMAN SANDERS:** Commissioner Rubin?

**COMMISSIONER RUBIN:** I was going to say I think this is a really great conversation.

For me, as I try to elevate -- this logic model is right there, it comes right after and starts to operationalize it and unpack it. I think this is about -- I think what I have learned over the last year and a half is that our failure to make a dent or improve the lives of our families and promote safety in our families is about a fundamental failure of shared accountability and responsibility and that this commission is proposing a reorganization of services delivered to families at the federal, state, and local level, and then you could say -- if we were going to create that directorate position, that would be an attention-grabbing headline, so that could have been it, in terms of -- I think it's failed responsibility and accountability across systems.

**COMMISSIONER PETIT:** I think people have a very hard time understanding that kind of language; across systems, failure of accountability, et cetera. I don't think it's strong enough in terms of visual with children. Children have to be the principle target.

**CHAIRMAN SANDERS:** Commissioner Cramer?

**COMMISSIONER CRAMER:** I just think we need to be very careful, Wade Horn, in that headline saying a billion dollars or X number of dollars, I mean, these are tough budget times and I just don't think we need to scream out with that. Child safety, yes, failed system, yes, strong follow-up recommendations, yes.

**CHAIRMAN SANDERS:** So it seems that we have the steps that we need to take and that we should actually -- we'll work on this document to include a single statement that reflects the importance of safety, touches on accountability, things like that. We'll figure something out that at least gets in front of people so that we can then debate that as well as this without the subheadings and then we can do that as this would help organize what we begin to write.

I would just say practically we ultimately -- we need to provide guidance by coming to some agreement at least at a high level where we want to go and I think that's the intent, but I think it's equally important to get it right and not to rush it. So I would suggest that we work on something. We can send it out far before the call, we should look for input from people on an ongoing basis, and then at the call have an opportunity to walk through this.

Commissioner Martin?

**COMMISSIONER MARTIN:** So one of the things I was thinking of just a minute ago -- and I have not put this next to our enacting legislation but when we talk about the roof, we talk about

measurement, this graph that has been developed, does our enacting legislation, does that all fit within this graph? I just want to make certain that we're not verging far from what we were told to do by Congress. So I just want to make certain that -- and again, I haven't laid it side by side and really did a comparative --

**CHAIRMAN SANDERS:** Well, Commissioner Martin, it seems like it depends on what we believe will be necessary to reduce child abuse and neglect fatalities because that is the heart of the request or the direction from Congress about the recommendations and so in addition to what are we going to track. I think that's the big part of the question, is the universe beyond this, is it less than this. This presumes these three elements are critical to neglect fatalities.

Commissioner Petit? This will be the last comment.

**COMMISSIONER PETIT:** I think we need to return to Commissioner Cramer's comment and I think he's absolutely right that getting the dollars that we need is going to be a challenge but I think --

**COMMISSIONER CRAMER:** I'd love to get them.

**COMMISSIONER PETIT:** But I think the reason why this commission exists is to help frame and change. And so the idea of a billion to me, knowing what I know about the system, is actually not a sufficient amount of money. I'm not going to argue for more than a billion at this point but I don't think we should be afraid of it and I know that you're not -- I think that what you're doing is highlighting the fact that it wouldn't be easy to get anything through. But I think that Commissioner Horn and others here recognize that whether you're Republican or Democrat, wherever you sit in the Congress, you don't want these kids to die, that part of is a non-partisan issue, and we start with one of the creators of this commission. And I think we just need to let this bubble up.

The headline isn't a billion dollars, the headline is kids dying and here's the response to what to do about it. That's what pulls people in. And I think, with all due respect to differences in the parties in terms of how they view the role of the federal government, right now the kinds of upstream things that we're talking about being cut or being proposed to be cut, but this public safety issue virtually always trumps everything and that's what I think has been missing is somebody trumpeting this particular question. I think that's what the commission does.

So my point is, Bud, on the billion dollars, we don't need to decide on that right now but I think it's a point well worth debating because in the end it's going to take money to do what we're talking about.

**COMMISSIONER CRAMER:** Can I ask a process question?

David, do you envision us eventually commission member by commission member voting yea or nay on a final report?

**CHAIRMAN SANDERS:** On the final report, yes. And we need either consensus on the direction at a high level that this kind of document reflects or we'll need to vote yes or no on that, too.

**COMMISSIONER CRAMER:** I assume that but I just want to be sure.

**COMMISSIONER HORN:** Commissioner Cramer, I know I have a reputation as a big spending guy - -

**COMMISSIONER CRAMER:** We've all noticed that.

**COMMISSIONER HORN:** I just think, you know, I would again go back to the National Commission on Children's report. The price tag on the thousand dollar refundable tax credit was about \$60 billion, something like that, and eventually it happened.

I think that the notion that -- if we really believe the system is in crisis, if we really believe that children are not being protected, if we really believe all of that, and I know you do, I don't think we should -- if we think there is a bold number that really would help and protect these kids' lives, I for one, and I know everybody on this commission will not shy away from recommending it even in tough budgetary times. And I think that the fact that this commission is bipartisan and includes a former Democratic congressman and others on one side of the political aisle as well as some of us on the other side of the political aisle adds enormous weight to the conversation about what kinds of resources need to be dedicated to dealing with the crisis.

**CHAIRMAN SANDERS:** Thank you.

So we have time set aside to talk about a conversation had in Los Angeles but we are over our time, so I think, Commissioner Ayoub, we should wait until the call to do that unless you have some opposition to that. Because looking around the room, people are really packed up and looking at their watches.

**COMMISSIONER AYOUB:** I totally understand. I'm sorry I'm not there with you.

Instead of waiting until the next meeting, I would propose that I just call each commissioner individually, it's a five to seven- minute update on it, so that wouldn't be on the agenda. So I'll be calling everybody next week.

And if anybody's sitting at the airport bored to death they could call me today.

**CHAIRMAN SANDERS:** Thank you, commissioner.

So we will get out a document that people can provide input on and we'll do that between now and the meeting, get as much feedback as possible, then we will have a discussion and hopefully come to consensus on this high level direction which will be in the report.

Thanks, everybody.

(Proceedings adjourned at 12:36 p.m.)

**MEETING ADJOURNED**