

# Preventing Negative Outcomes for Children at Risk via Identification and Treatment of their Parents: The Montefiore Experience

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THE PEDIATRIC HOSPITAL FOR:



Albert Einstein College of Medicine  
OF YESHIVA UNIVERSITY

American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Organizational Principles to Guide and Define the Child  
Health Care System and/or Improve the Health of all Children

## POLICY STATEMENT

# Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health

*“Identifying children at high risk for toxic stress is the first step in providing targeted support for their parents and other caregivers.”*



THE PEDIATRIC HOSPITAL FOR:



Albert Einstein College of Medicine  
OF YESHIVA UNIVERSITY

NATIONAL SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD  
NATIONAL FORUM ON EARLY CHILDHOOD POLICY AND PROGRAMS

Center on the Developing Child  HARVARD UNIVERSITY

# The Foundations of Lifelong Health Are Built in Early Childhood

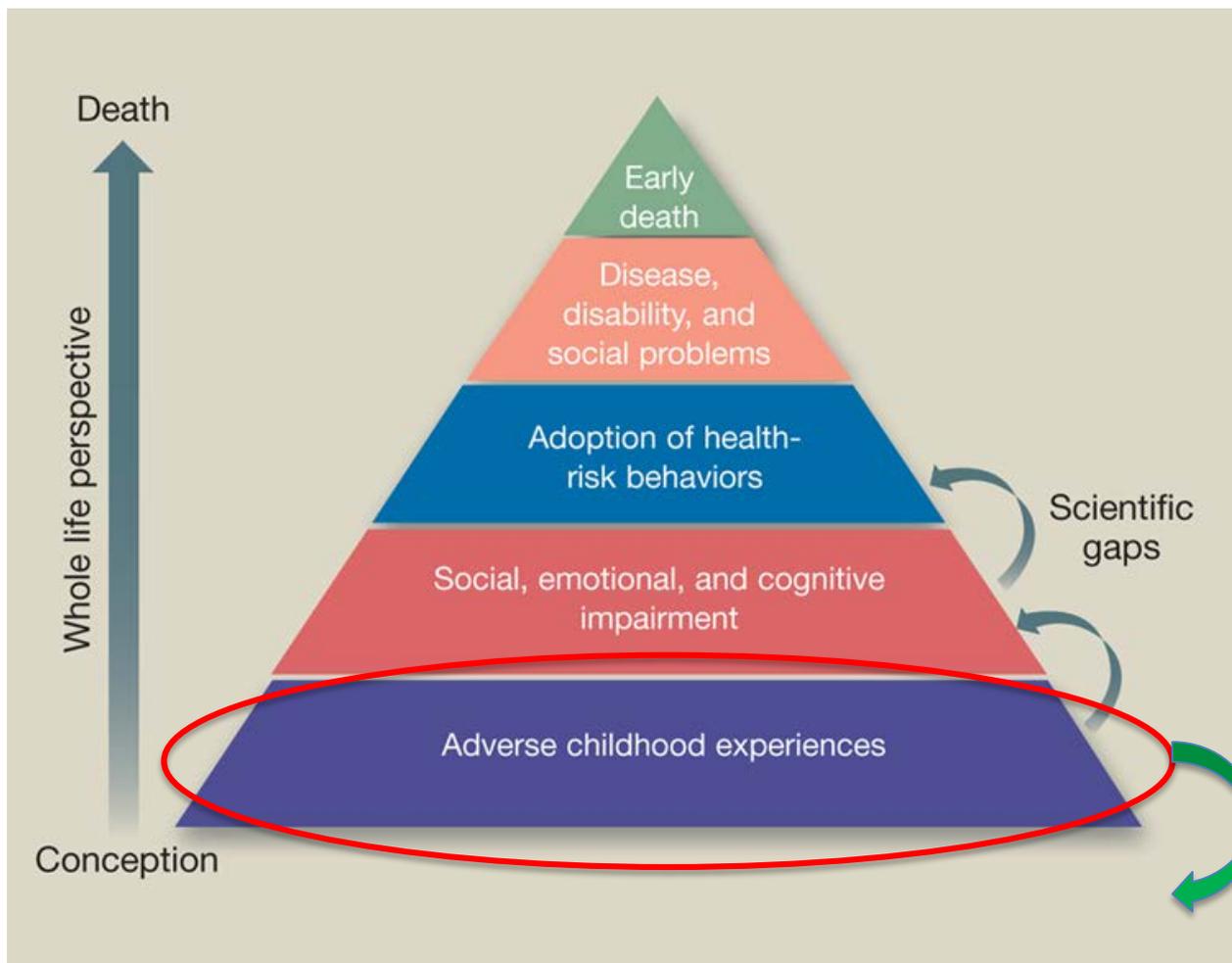
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*“Health in the earliest years – actually beginning with the future mother’s health before she becomes pregnant – lays the groundwork for a lifetime of well-being.”*

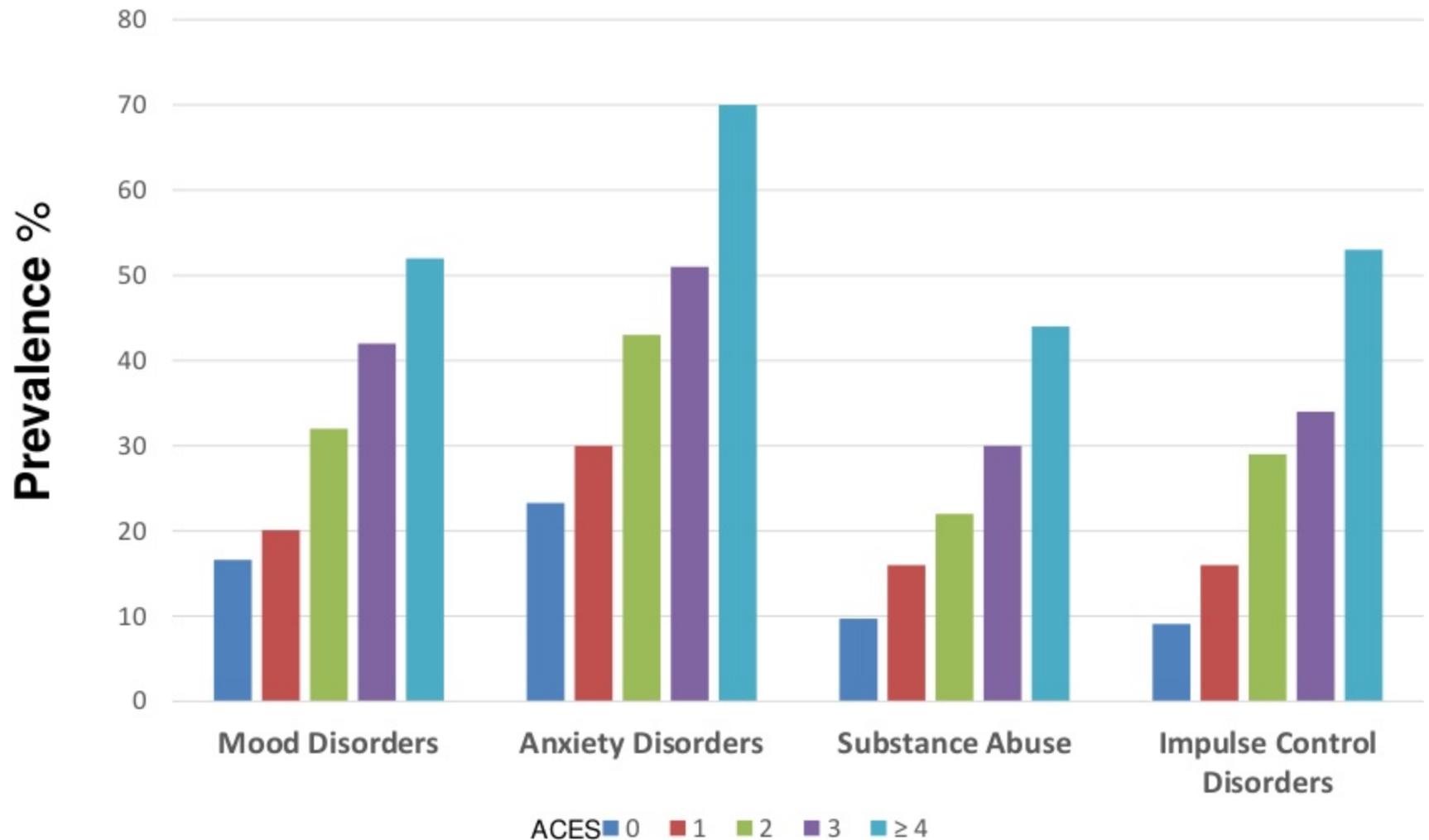


# The Primary Care Challenge

- Is there an opportunity to identify children at risk of maltreatment with the primary care setting?
- If so, how early can we identify children who would benefit from specific preventive or therapeutic interventions to optimize their developmental potential, and decrease maltreatment occurrences?
- What tools are available in primary care to accomplish this function and how should they be administered?



# Cumulative ACES & Mental Health<sup>1,2</sup>



# Parental Mental Health and Child Maltreatment

- **Children with parents suffering from poor mental health are at greater risk of death than children with healthy parents.**

Bourget, D., Grace, J., & Whitehurst, L. (2007); Webb, R., Abel, K., Pickles, A., & Appleby, L. (2005); King-Hele, S. A., Abel, K. M., Webb, R. T., Mortensen, P. B., Appleby, L, & Pickles, A. (2007).

- **Parents suffering from poor mental health perpetrate child maltreatment at greater rates and with greater severity, compared to healthy parents.**

Sidebotham, P., Golding, J., & the ALSPAC Study Team. (2001). Chemtob, C. M., Gudino, O. G., & Laraque, D. (2013).

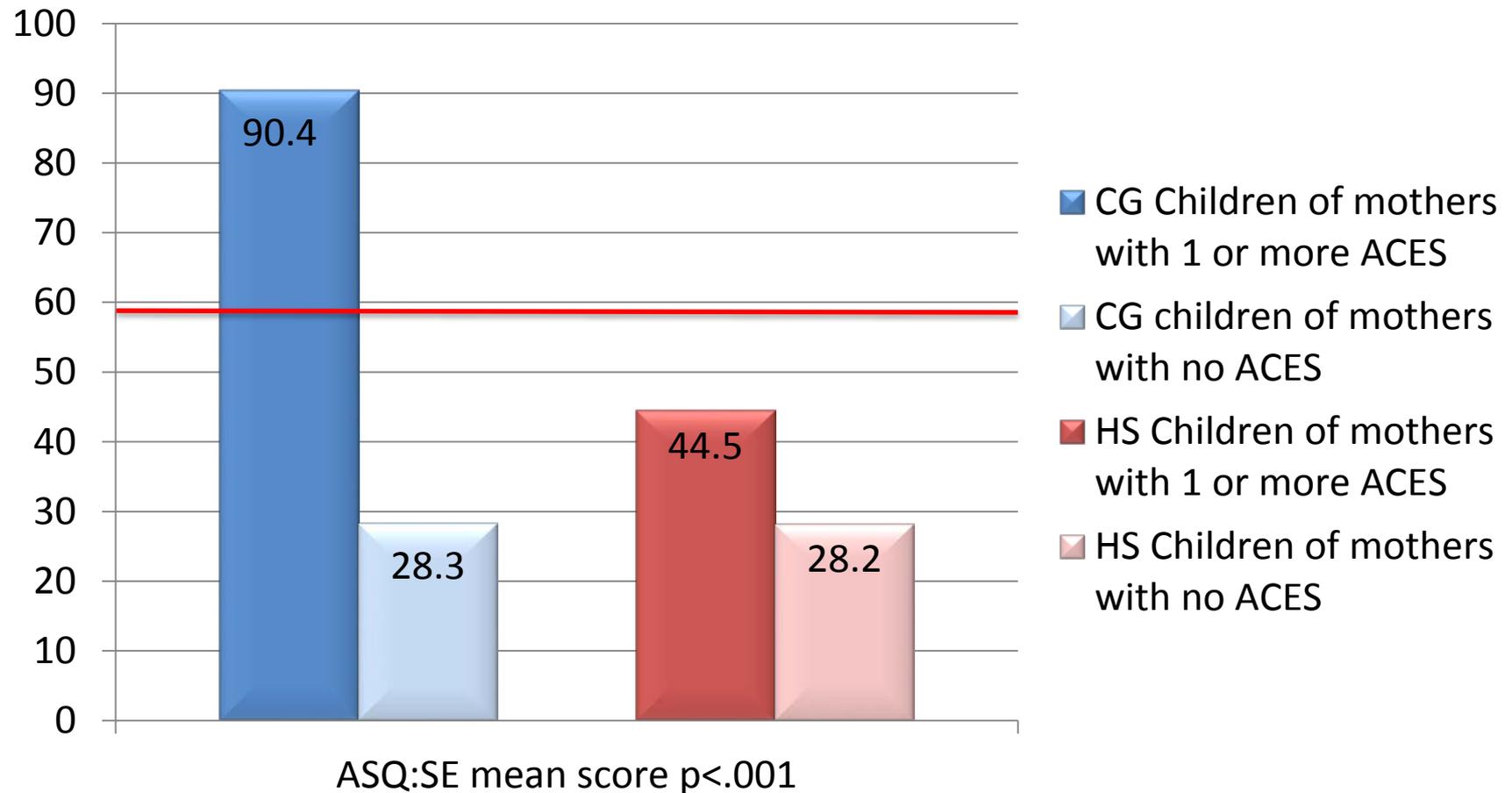
# Parental Mental Health and Child Development

- **Several aspects of children's development can be affected by parental mental health concerns, including their physical, cognitive, social, emotional, and behavioral development.**
- **Mechanism is more likely to be parenting than genetic.**

Sources: Barnes J, Stein A. Effects of parental psychiatric and physical illness on child development. In: Gelder M, Lopez-Ibor JJ, Andreasen N, ed. New Oxford textbook of psychiatry. Oxford: Oxford University Press, 2000.

Murray L, Cooper P. Intergenerational transmission of affective and cognitive processes associated with depression: infancy and the preschool years. In: Goodyer I, ed. Unipolar depression: a lifespan perspective. Oxford: Oxford University Press, 2003.

# Interaction – Impact of Intervention on 36 month ASQ:SE scores by Maternal ACES

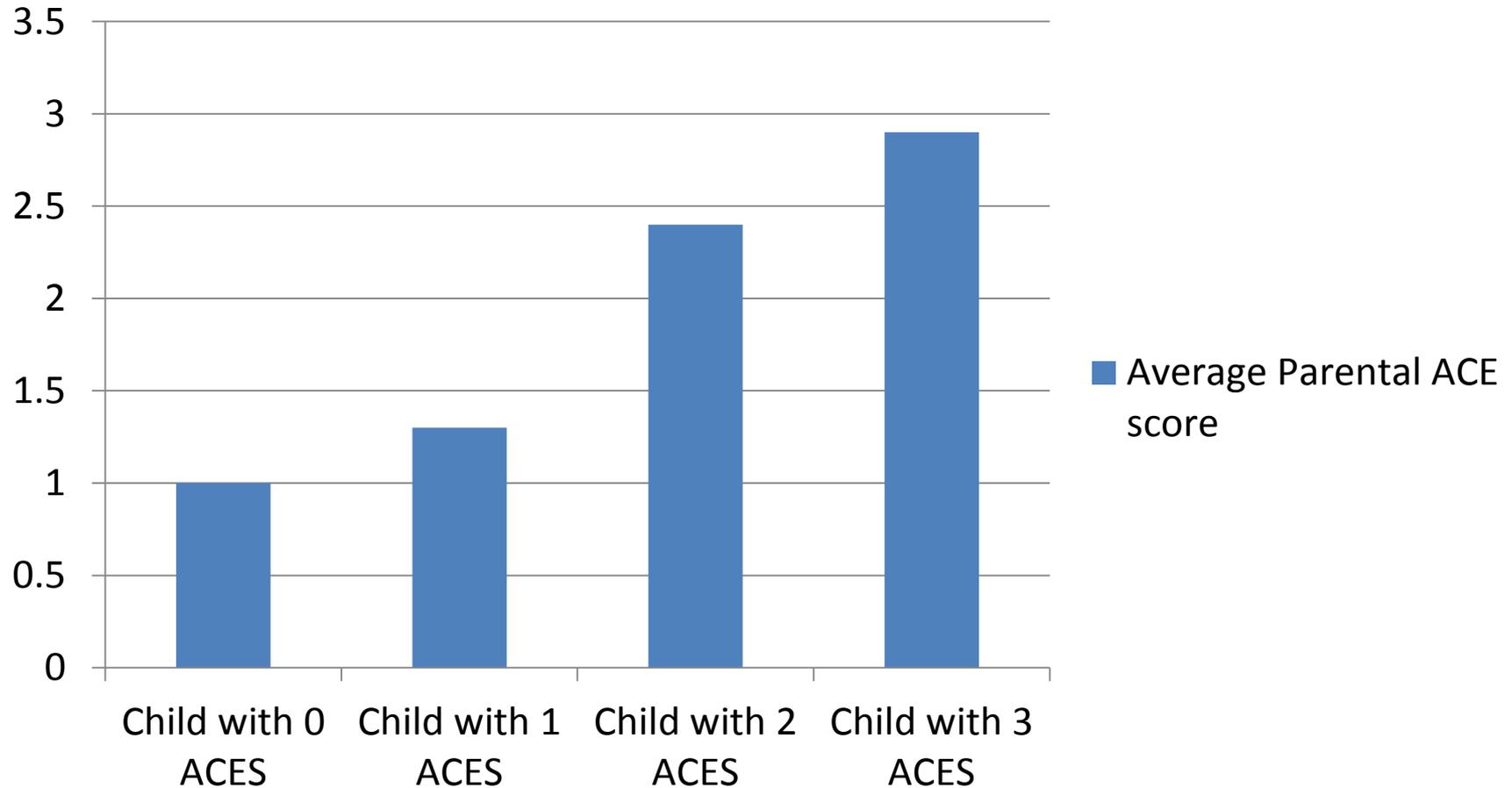


Briggs, et al. (2014). Healthy Steps as a Moderator: The Impact of Maternal Trauma on Child Social-Emotional Development. *Clinical Practice in Pediatric Psychology* (2, 2), 166–175

# Current state of ACES screening at Montefiore

- Universal ACES screening at newborn visit, to help determine families who might benefit from Healthy Steps Intensive Services: N=1282 parents and 1024 children
- Average percent of parents who endorse at least one ACE = 59%
- Average percent of parents who endorse at least one ACE for their newborn child = 40%

# Child ACES and their average Parental ACE score



# Policy Recommendations

- Payment reform must go beyond screening and include dyadic work, prevention, etc.
- Redefine medical necessity to reflect, for example, the risk of being born to a mother with depression.
- Capitated payment rate to reimburse for practices that have behavioral health staffing.

# Acknowledgements

- Altman Foundation
- Center for Medicaid and Medicare Innovation
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- Marks Family Foundation
- NYC City Council Children's Mental Health under 5 Initiative
- Price Family Foundation
- Stavros Niarchos Foundation
- Tiger Foundation



# A Dual-Generation Approach to Preventing Maltreatment Fatalities: Intervening in Adolescence



**Angela Diaz, MD, MPH**

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Jean C. and James W. Crystal Professor  
in Adolescent Health

Professor of Pediatrics, and Preventive Medicine,  
Icahn School of Medicine at Mount Sinai



**Mount  
Sinai**

# Child Maltreatment Fatalities

**Child maltreatment fatalities are usually associated with:**

- ❑ **A history of child maltreatment**
  - Parental substance abuse
  - Parental depression
  - Child maltreatment history in parents
- ❑ **Early age of child birth (teen birth)**
- ❑ **Multiple children who are closely spaced**
- ❑ **Teen dating violence and domestic violence**
- ❑ **Multiple stressors**
- ❑ **Inadequate social support**
- ❑ **Lack of resources**

# Adolescents, Caregiving, and Maltreatment

**Adolescent girls with a history of maltreatment are more likely to have children than their non-maltreated peers**

- ❑ Adolescents with a history of maltreatment have higher pregnancy rates regardless of poverty status
  
- ❑ In 2009 in California, approximately:
  - 45% of adolescent mothers who gave birth reported prior histories of maltreatment
  - 21% had been substantiated victims
  - 10% had spent time in foster care

SOURCE: Putnam-Hornstein, E., Cederbaum, J.A., King, B., Cleveland, J., & Needell, B. (2013). A population-based examination of maltreatment history among adolescent mothers in California. *Journal of Adolescent Health* 2013; 1-4.

# Adolescents, Caregiving, and Maltreatment

**Adolescent mothers are more likely to experience compounding life stressors, that include:**

- Depression
- Stress
- Domestic violence
- Substance use
- Delay or failure to receive prenatal care

SOURCES: Care of Adolescent Parents and Their Children. Committee on Adolescence and Committee on Early Childhood, Adoption, and Dependent Care. Pediatrics 2001; 107:429-434.

Chen CH. Postpartum depression among adolescent mothers and adult mothers. The Kaohsiung Journal of Medical Sciences 1996; 12(2):104-113.)

# Adolescents, Caregiving, and Maltreatment

## A mother's young age is a risk factor for maltreating and fatally maltreating her child

- Children of young mothers are more likely to be placed into foster care or experience a shift in their primary caregiver
- The most important risk factor for infant homicide is multiple children born to a mother under 17 years of age
- Children of mothers under age 25 are more likely to become victims of fatal inflicted injuries

SOURCES: Risk Factors for Infant Homicide in the United States. Overpeck, M.D., Brenner, R., Trumble, A., Trifiletti, L., and Berendes, H. N Engl J Med 1998; 339:1211-1216.)

Stier, DM, Leventhal, JM, Berg, AT, Johnson L, Mezger, J. Are Children Born to Young Mothers at Increased Risk of Child Maltreatment? Pediatrics 1993; 91:642 - 648.)

Child Deaths Resulting From Inflicted Injuries: Household Risk Factors and Perpetrator Characteristics. P Schnitzer and B Ewigman. Pediatrics 2005; 116:687-693.)

# Intervening with Adolescents

- ❑ **Adolescents often lack a source of regular health care, but seek treatment related to reproductive health**
  - The leading reason for health care visits among middle and late adolescent females is obstetrical-gynecological examination, and the leading diagnosis among this same population is pregnancy
  - A repeat pregnancy occurs within 2 years of the first birth in 35% of adolescent mothers
- ❑ **Reproductive health services are an access point to provide services and support to young mothers and their children**
  - Pregnancy and postpartum are identified as high-risk periods for discontinuation health care for non-reproductive conditions, such as depression and medication for mental illness

SOURCES Ziv, A., Boulet, JR., Slap, GB. Utilization of Physician Offices by Adolescents in the United States. Pediatrics 1999; 104:35-42.

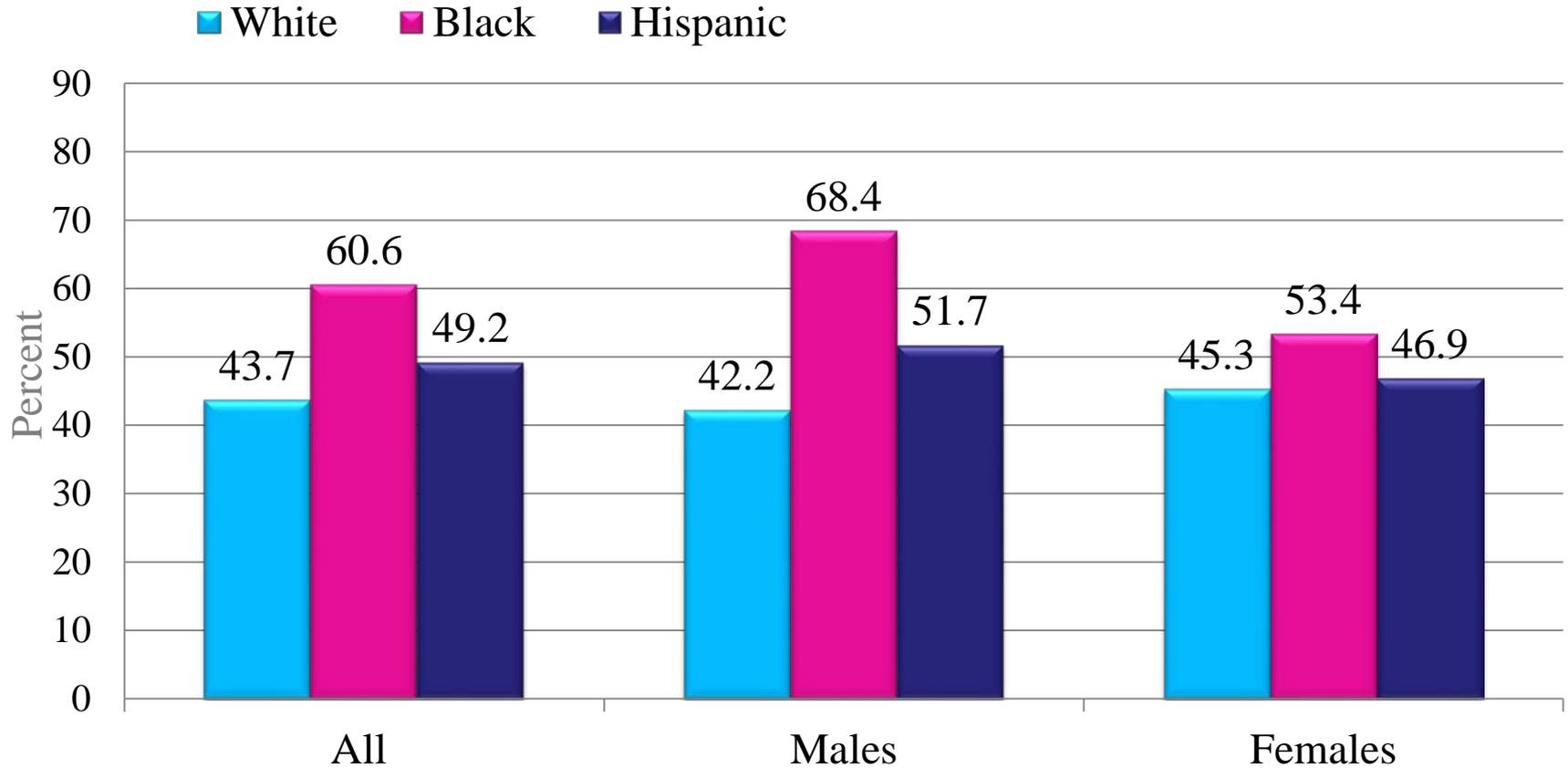
East PL, Felice ME. Adolescent Pregnancy and Parenting: Findings From a Racially Diverse Sample. Mahwah, NJ: Lawrence Erlbaum Associates; 1996.

Bennett IM, Marcus SC, Palmer SC, Coyne JC. Pregnancy-related discontinuation of antidepressants and depression care visits among Medicaid recipients. Psychiatric Services 2010;61(4):386-391.

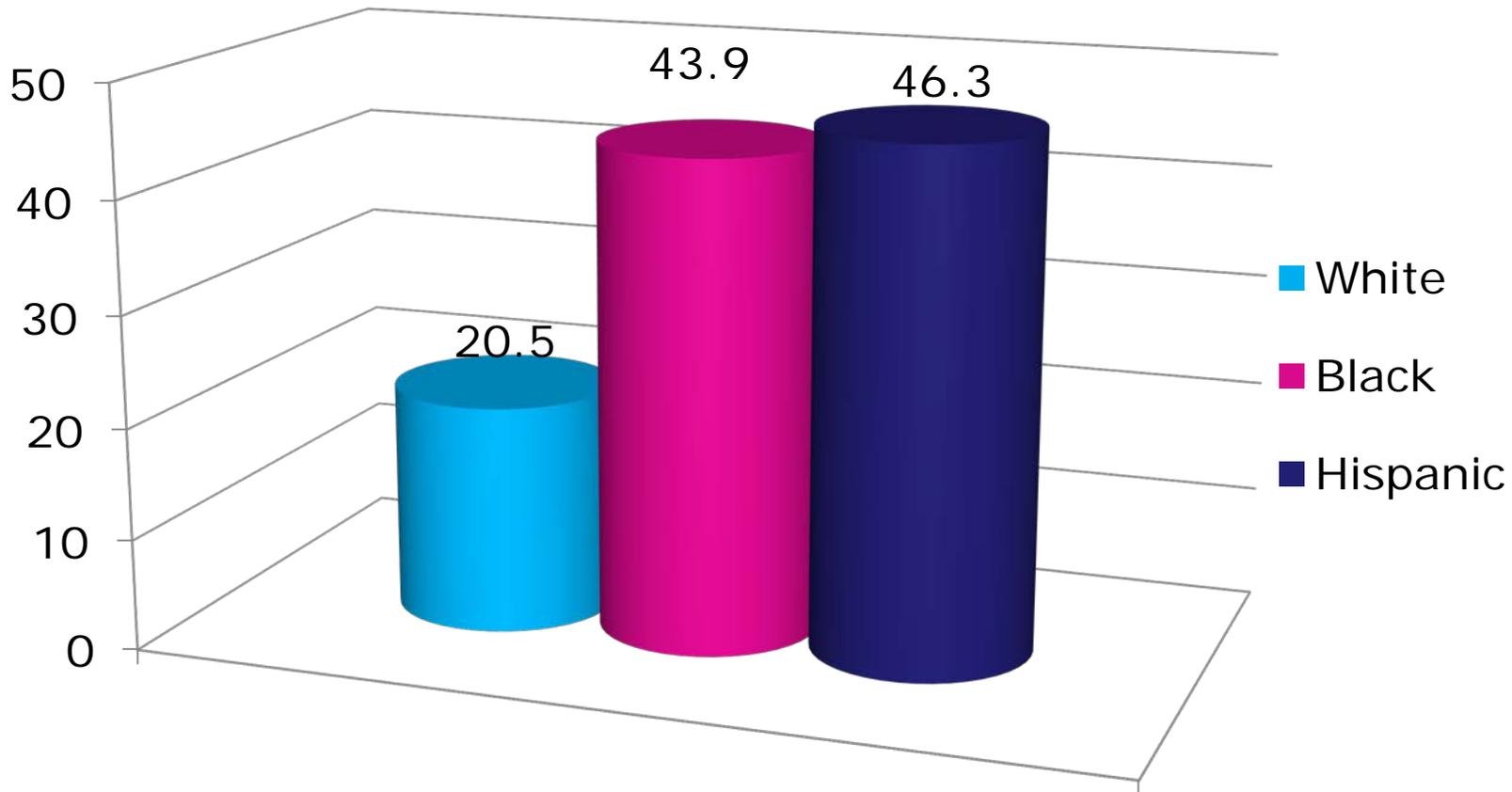
# Teens' Sexual Behaviors National Statistics



# % U.S. High School Students Who Report They “Ever Had Sex” By Race/Ethnicity and Gender



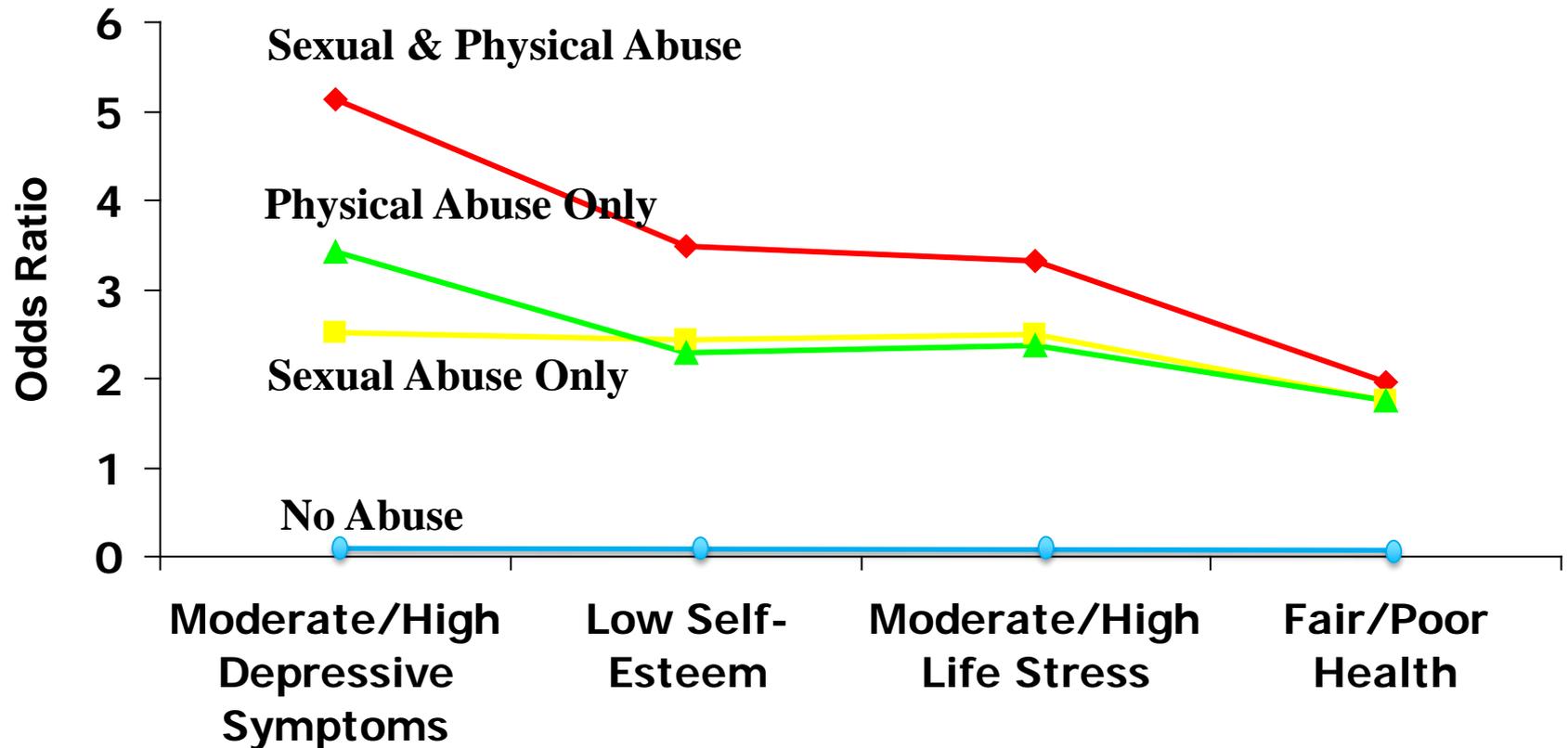
# Teen Birth Rates in 2012: Rates per 1,000 in Teens Ages 15-19, by Race, and Ethnicity



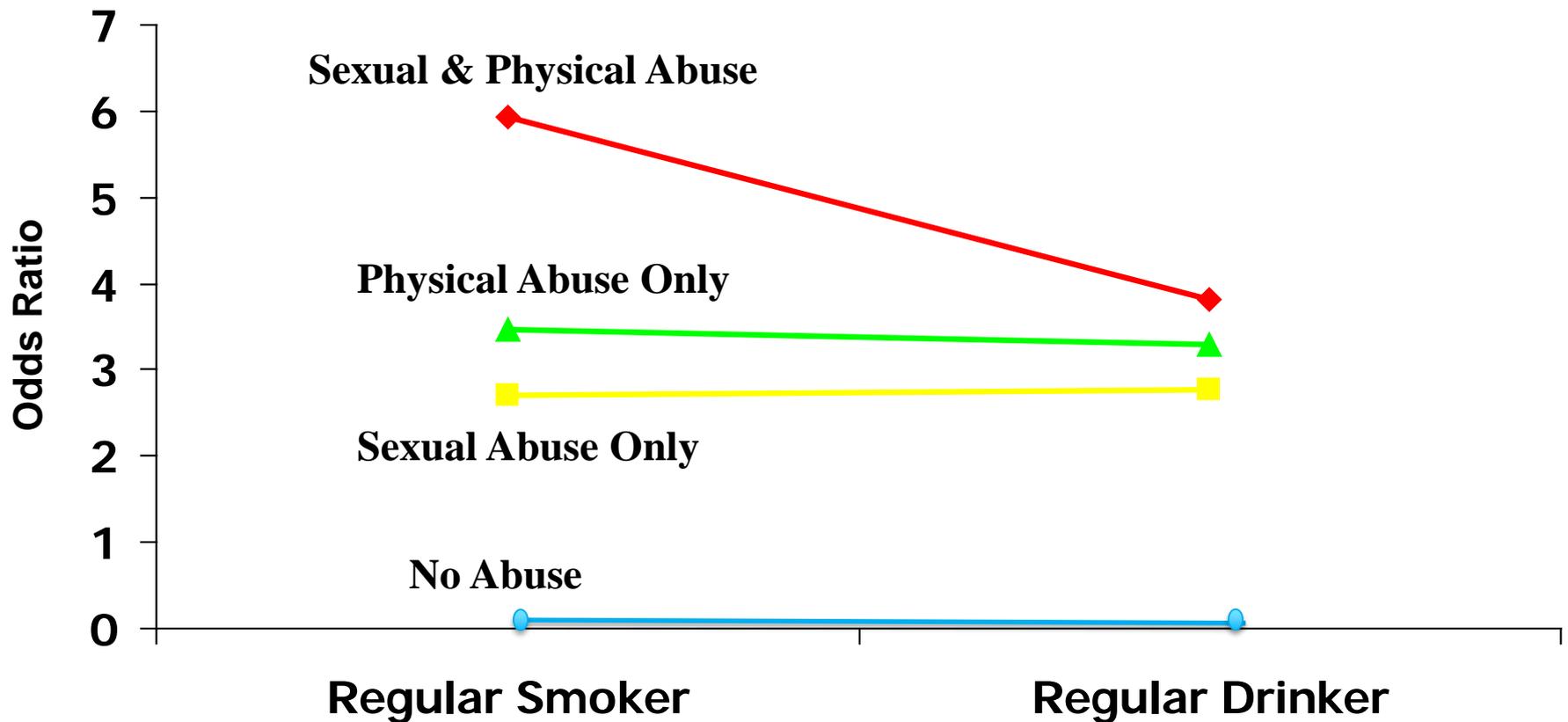
**Overall teen birth rate in 2012 was 29.4 for every 1,000 adolescent females**

The National Campaign to Prevent Teen Pregnancy Report 2013

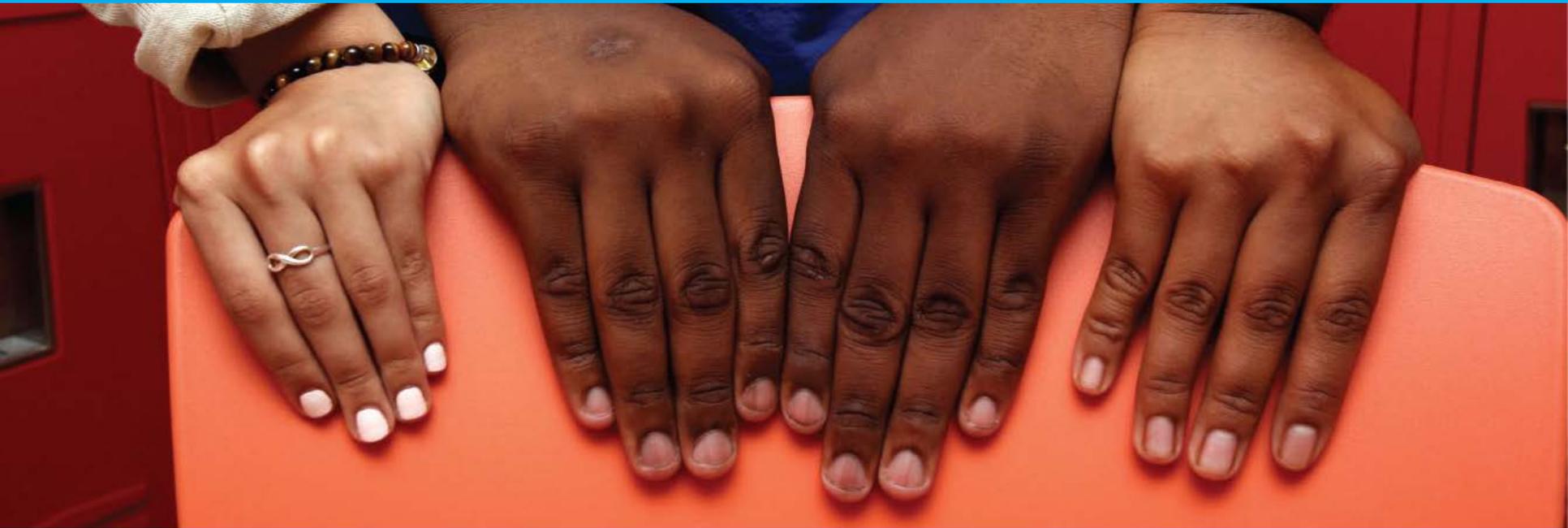
# Independent Associations Between Abuse, Mental Health, and Health Status



# Independent Associations Between Abuse and Substance Use



# Mount Sinai Adolescent Health Center Sexual Abuse Study



# Sexual Abuse and Adolescents

- ❑ **23% of patients disclosed a history of sexual abuse when asked directly during a routine medical screening**
- ❑ **81% of these patients accepted referrals to counseling as a result of this disclosure**

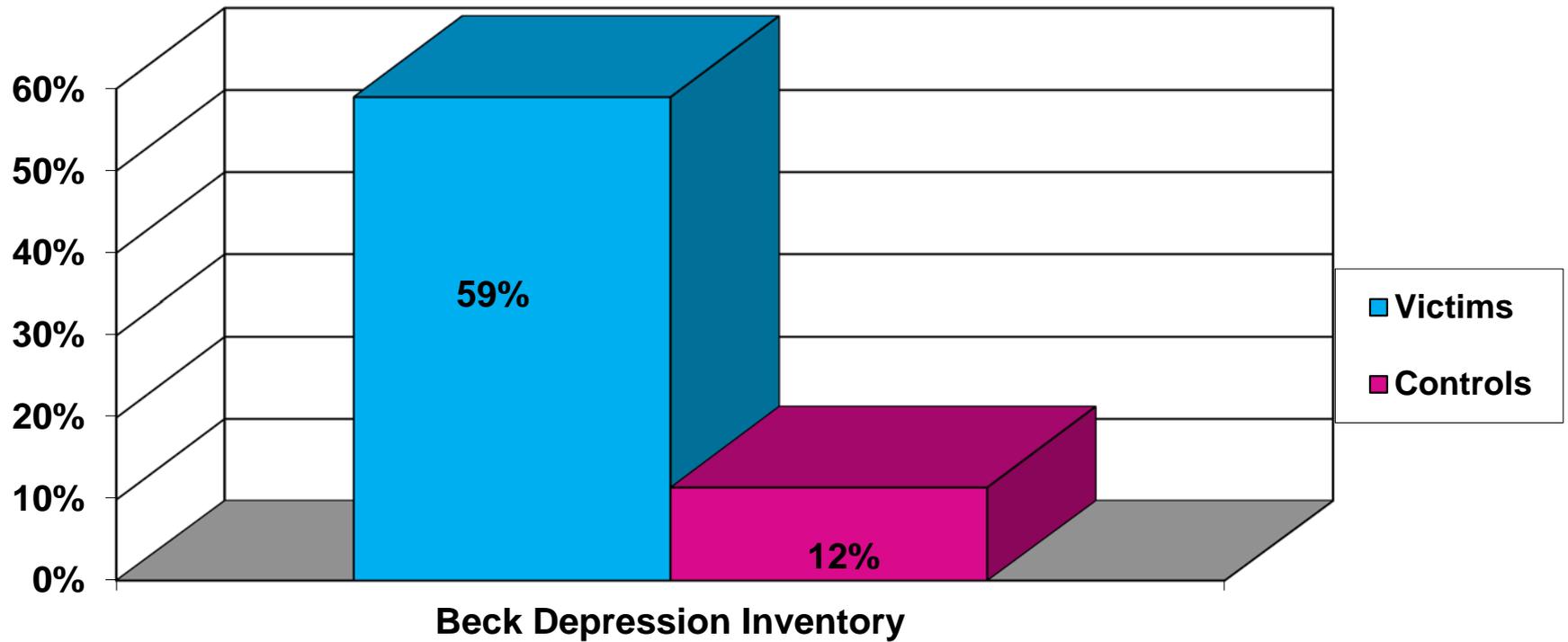
# Total Number of Perpetrators

	<b>Victims</b>	<b>Perpetrators</b>
	<b>N</b>	<b>N</b>
One	67	67
Multiple	33	98
<b>Total</b>	<b>100</b>	<b>165</b>

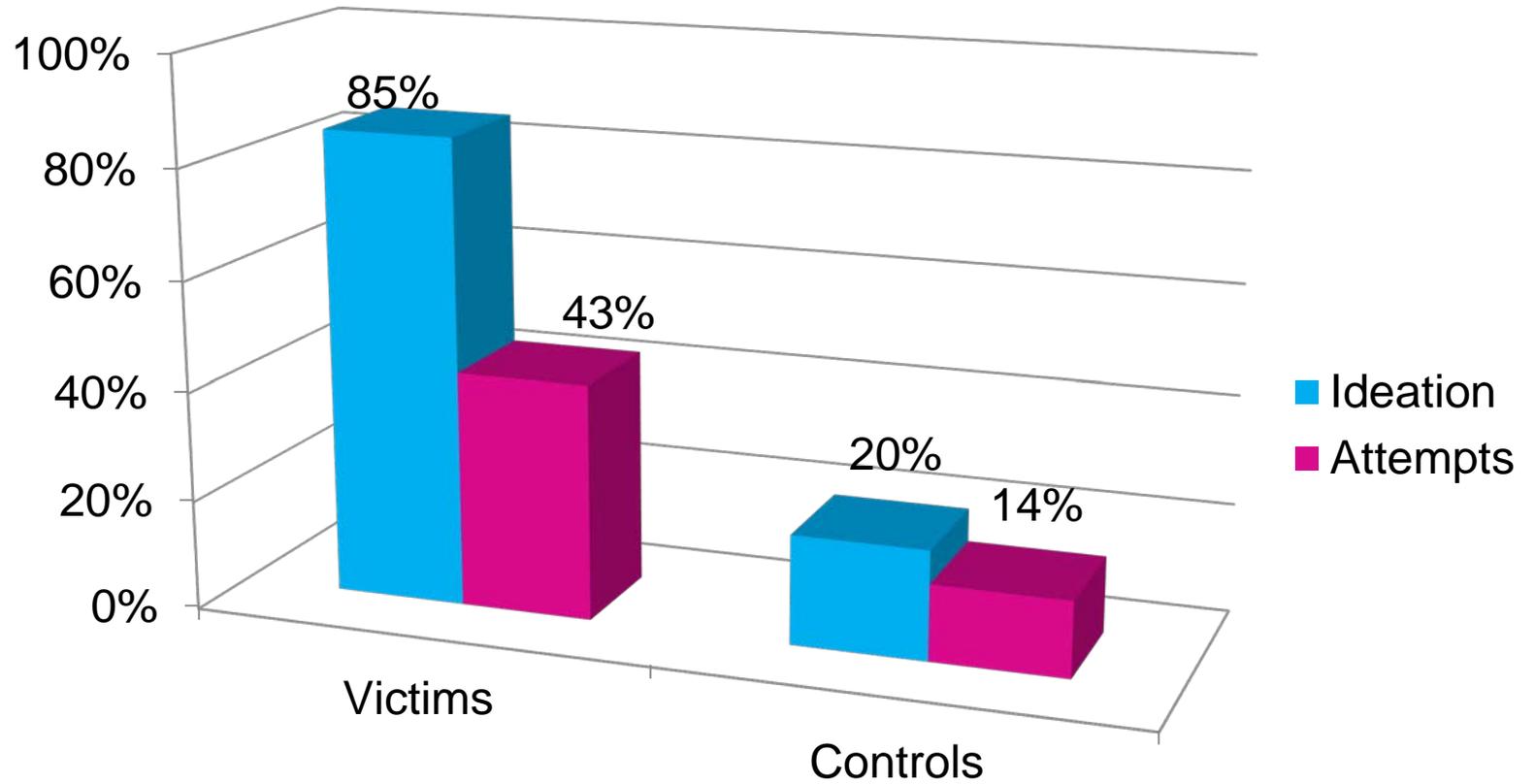
# Age at Onset of Sexual Abuse

- ❑ 70% of abuse began pre-pubertal
  - For 51% of females, abuse started and ended before menstruation
  - For 19% of females, abuse started before menstruation and ended after
- ❑ 30% of abuse began after menstruation

# Comparison of Depressive Symptoms



# Suicidality



# Additional Victimization

<b>Abuse</b>	<b>%</b>
physical	68
emotional	59
other sexual assault	28

<b>Relationship status</b>	
current	52
never	17

<b>Relationship abuse</b>	
ever	83
abusive	25

# Policy Recommendations to Strengthen Maltreatment Fatality Prevention

- ❑ **Prevention is getting it right from the start!**
- ❑ **Children in child protection need more than safety - they need interventions**
- ❑ **Screen adolescents – including pregnant and parenting teens - for a history of child maltreatment, depression and substance use**
- ❑ **Connect them to interventions: ensure access to services where history is identified**
- ❑ **Integration – or at a minimum a high level of coordination – of primary care, sexual and reproductive health, mental health and substance abuse prevention/treatment**
- ❑ **All services for adolescents should be trauma informed**

# Policy Recommendations to Strengthen Maltreatment Fatality Prevention

- ❑ **Ensure adolescents have access to health education including comprehensive sexuality education in schools and during health care**
- ❑ **Ensure adolescents have access to reliable family planning methods**
- ❑ **Make sure adolescents who are having a baby get timely prenatal care and have access to reliable contraception after delivery**
- ❑ **Invest in early childhood development services and ongoing prevention services at every stage including adolescence**

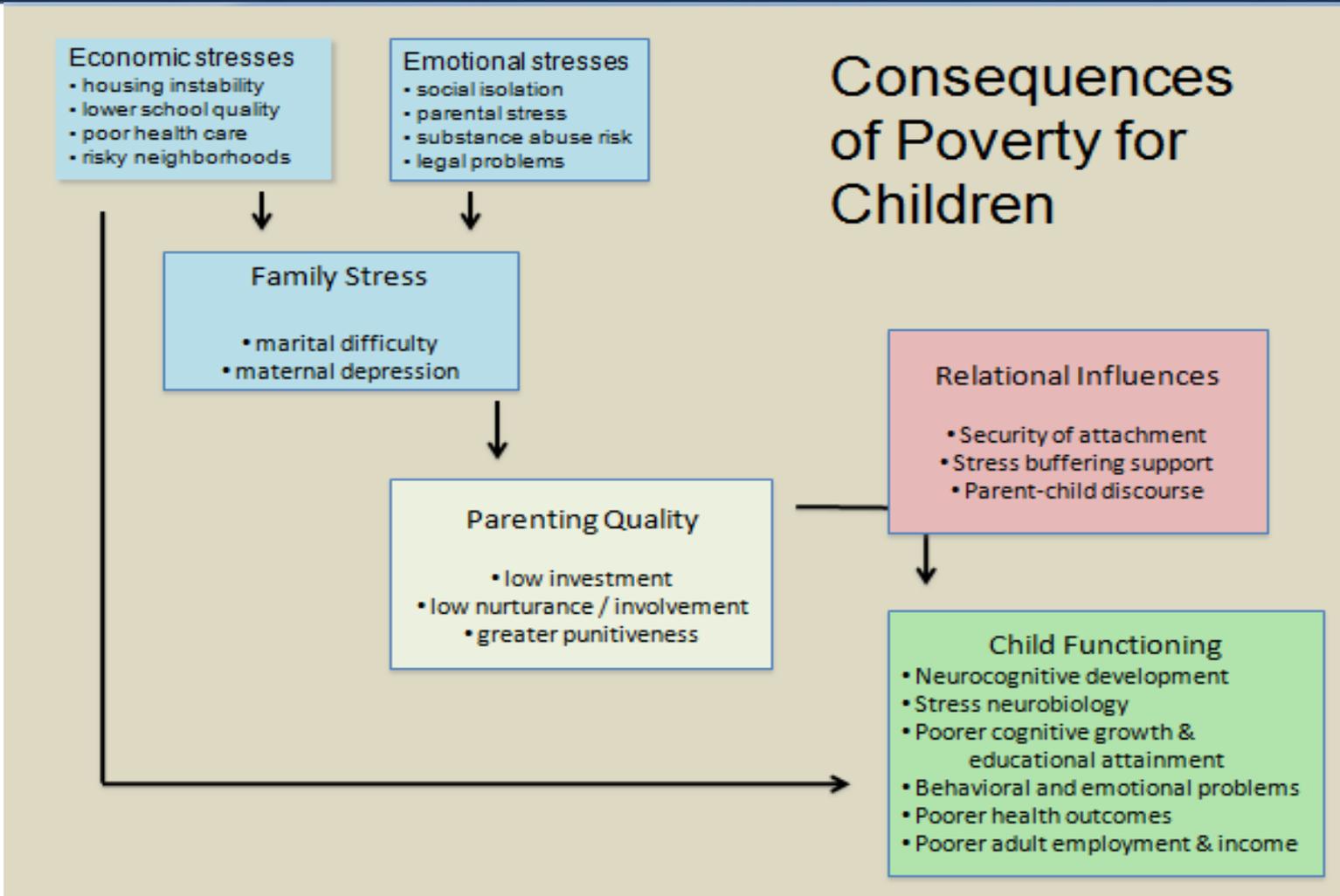
# Mount Sinai Adolescent Health Center



# Building for Success: Universal Evidence-Based Maternal Home Visiting



# Consequences of Poverty for Children



# What is Evidence-Based?

- **Evidence-Based** means a program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from a systemic review demonstrates sustained improvements in at least one outcome.

# What is Maternal Home Visiting?

- **Maternal Home visiting** is a voluntary, home-based prevention strategy used to support pregnant mothers and new parents to promote infant and child health, foster healthy child development, prevent child abuse and neglect, and improve school readiness and family self-sufficiency. Services are most often delivered by trained nurses, social worker or child development specialists.

# Evidence-Based Home Visiting Models

Model	Target Population
Nurse-Family Partnership	<p><b>Eligibility:</b> Designed for first-time, low-income mothers and their children. Requires a client to be enrolled in the program early in her pregnancy and to receive a first home visit no later than the end of the woman's 28th week of pregnancy.</p> <p><b>Services:</b> Pregnancy until the child is 2 years old.</p>
Healthy Families	<p><b>Eligibility:</b> HFA sites select the specific characteristics of the target population they plan to serve (e.g. first-time parents, parents on Medicaid, or parents within a specific geographic region). Families complete assessment to determine the presence of risk factors.</p> <p><b>Services:</b> Prenatally or at birth until child is 3-5 years old.</p>
Parents as Teachers	<p><b>Eligibility:</b> Affiliates select eligibility criteria of the target population they plan to serve (e.g. children with special needs, families at risk for child abuse, income-based criteria, teen parents etc.).</p> <p><b>Services:</b> Pregnancy through kindergarten entry.</p>

# Evidentiary Foundations of Nurse-Family Partnership

Relative to Nurse-Family Partnership's program goals, the following outcomes have been observed among program participants compared to their counterparts assigned to the control group in at least one randomized trial:

## Improved pregnancy outcomes

- 35% fewer cases of pregnancy-induced hypertension<sup>7</sup>
- 79% reduction in preterm delivery among women who smoke cigarettes<sup>8</sup>
- 31% reduction in very closely spaced (<6 months) subsequent pregnancies<sup>12</sup>

## Improved child health and development

- 39% fewer healthcare encounters for injuries or ingestions in the first two years of life among children born to mothers with low psychological resources<sup>22</sup>
- 56% reduction in emergency room visits for accidents and poisonings in the second year of the child's life<sup>11</sup>
- 48% reduction in state-verified reports of child abuse and neglect by child age 15<sup>20</sup>
- 50% reduction in language delays by child age 21 months<sup>9</sup>
- 5 point increase in language scores on a test with a mean of 100 and standard deviation of 15 among 4-year-old children born to mothers with low psychological resources<sup>17</sup>
- 67% reduction in behavioral and emotional problems at child age 6<sup>16</sup>
- 9 percentile increase in math and reading achievement test scores in grades 1-3 among children born to mothers with low psychological resources<sup>23</sup>
- 67% reduction in 12-year-old children's use of cigarettes, alcohol, or marijuana<sup>24</sup>
- 28% reduction in 12-year olds' mental health problems (depression and anxiety)<sup>24</sup>
- 3 point increase in 12-year-old children's reading and math achievement test scores on a test with a mean of 100 and standard deviation of 15 among those born to mothers with low psychological resources<sup>24</sup>
- 6 percentile increase in group-based reading and math achievement test scores in grades 1-6 among children born to mothers with low psychological resources<sup>24</sup>
- 59% reduction in arrests by child age 15<sup>21</sup>
- 90% reduction in adjudication as PINS (person in need of supervision) for incorrigible behavior<sup>21</sup>
- 33% fewer arrests among female children at age 19<sup>26</sup>
- 80% fewer convictions among female children at age 19<sup>26</sup>
- 73% increase in age at 1st arrest among female children at age 19<sup>26</sup>
- 82% fewer current arrests among female children at age 19<sup>26</sup>
- 89% fewer current convictions among female children at age 19<sup>26</sup>

## Increased self-sufficiency of the family

- 1 month increase in labor force participation during second year of child's life<sup>9</sup>
- 46% increase in father presence in household by child age 4<sup>12</sup>
- 30-month reduction in use of AFDC-TANF among mothers who were poor and unmarried at registration<sup>13</sup>
- 7 month (or 82%) increase in labor force participation 4 years after delivery of first child among low-income unmarried mothers<sup>14</sup>
- 1.75 month reduction in use of AFDC-TANF between child age 5 and age 6<sup>16</sup>
- 1.83 month reduction in use of Food Stamps between child age 5 and 6<sup>16</sup>

# Evidentiary Foundations of Healthy Families



*supporting parents right from the start*

## PROVEN BENEFITS TO CHILDREN, FAMILIES AND COMMUNITIES



Healthy Families (HF) Home Visiting has demonstrated a consistent, positive result for the well being of participants across the nation and here in New York.

### CHILDREN

- In Randomized Controlled Trials(RCT) conducted in NY, fewer Healthy Families New York(HFNY) children received special education services once they entered school.
- The same study found that HFNY children of first time mothers were less likely to score below average on cognitive scales.

Other nationwide findings indicate:

- Reduced rates of retention in 1<sup>st</sup> grade.
- Increased percentage of children who scored above grade level on behaviors that promote learning.
- Increased percentage of girls who scored above grade level academically.

HFNY is an evidence based, voluntary home visiting program for expectant and new parents. Highly-trained paraprofessionals use a strength-based approach to families and may provide intensive in-home services until age four. The goals of HFNY are to promote positive parenting skills and parent-child interaction, prevent child abuse and neglect, promote optimal prenatal care and child health and development, and enhance family self-sufficiency.

### FAMILIES

- RCT studies of NY families found mothers half as likely to have **low birth weight** babies as those who did not receive HFNY services.
- 3.1% of African American mothers in HFNY had low birth weight babies as compared to 10.2% of non-program African American mothers.
- NY RCT produced sustained reductions in maternal reports of **harmful parenting** practices for the whole sample at ages one, two and seven.
- Other RCTs found parents **academically advanced** to a higher educational level between intake and 24 months postpartum, and significantly more reported they had attended GED classes.

### COMMUNITIES

- Enrolled families were more likely to actually receive certain types of needed services including immigration assistance/services, daycare/babysitting, and English as a Second Language instruction.
- HF studies show enrolled mothers are waiting to have another child, which impacts the health of both moms and babies, as well as helping young families achieve greater financial security.
- HF participants have been found to be more likely to use primary care services and avoid unnecessary emergency room services.

# Evidentiary Foundations of Parents as Teachers

## Children's developmental delays and health problems are detected early:

- > Approximately 23,000 children every year are newly identified with a developmental delay or problems with vision, hearing, or health (including mental health)<sup>10</sup>.
- > PAT children were five times more likely to be fully immunized<sup>4</sup>.



## Child abuse and neglect is prevented:

- > Parents as Teachers children were less likely to be treated for injury<sup>4</sup>.
- > PAT participation was related to 50% fewer cases of suspected abuse and/or neglect<sup>5</sup>.

## Children enter kindergarten ready to learn and the achievement gap is narrowed:

- > PAT children scored higher on measures of achievement, language ability, social development, persistence in task mastery and other cognitive abilities<sup>12</sup>.
- > Parents as Teachers combined with quality preschool education reduced the achievement gap between low-income and more advantaged children at kindergarten entry. More than 75% of the low-income children who participated in PAT and preschool were rated by their teachers as ready for kindergarten<sup>13</sup>.
- > Teachers rated PAT children significantly higher than non-PAT children on multiple, developmental indicators of school readiness (emotional well-being, fine motor, expressive language, receptive language and social competence)<sup>14</sup>.

## Children achieve school success into the elementary grades:

- > PAT children scored higher on standardized measures of reading, math and language in elementary grades<sup>15</sup>.
- > Compared to non-PAT children, PAT children required half the rate of remedial and special education placements in 3rd grade<sup>16</sup>.



*"How different our story would have been without Parents as Teachers! We owe them a lot, not only because they helped with Daniel's educational development, but because they may also have saved his life."*

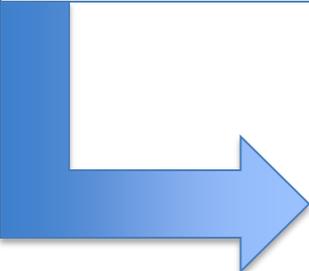
*"It wasn't until I started working with our parent educator that I realized just how far behind Izaya was. Eventually we got a diagnosis: autism. Parents as Teachers gave me the tools and information to move in the right direction. Those visits continue to*

# Universal Home Visiting

- Program:  
**Evidence-Based Home Visiting**
- Eligibility:  
**All new Medicaid Births**
- Accessibility:  
**Offered to every eligible mother at earliest pre-natal visit**
- Participation:  
**50% of eligible mothers participate**

# How Much Would Universal Home Visiting Cost?

- With universal access and aggressive outreach:  
**60,000 annual enrollees**
- Overall State and Federal Spending in NYS for these programs FY2011:  
**\$43 Million**
- Overall annual cost of Universal Home Visiting in NYS:  
**\$299 Million**
- Overall annual new cost of Universal Home Visiting in NYS:  
**\$256 Million**



**Evidence-Based Programs ROI:** Up to \$5.70 per taxpayer dollar invested by reducing future costs associated with child abuse and neglect, poor health, academic failure.<sup>1</sup>

<sup>1</sup> National Conference of State Legislatures, "Maternal, Infant, and Early Childhood Home Visiting Programs."

# How to Pay for Universal Home Visiting

- **Medicaid**
  - NFP is one of 25 strategies that hospital applicants can select under “Public Health Innovation” for a Delivery System Reform Improvement Payment project to help reduce avoidable hospitalizations under the State Medicaid waiver.
- **Federal Level Funding**
  - The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) allocated \$1.5 billion in funds for home visiting programs between 2010 and 2014.
- **State Level Funding**
  - In NYS, 27 Senators and 32 Assemblymembers, a bipartisan group from both houses, signed a letter to Governor Cuomo supporting the expansion of Evidence-Based Home Visiting.
- **Social Impact Bonds**
  - Government “bonds” for which investors provide program costs upfront, public sector covers transaction and evaluation costs. If program meets benchmarks, investors paid on regular, pre-determined basis, with interest; if not, gov’t does not pay.

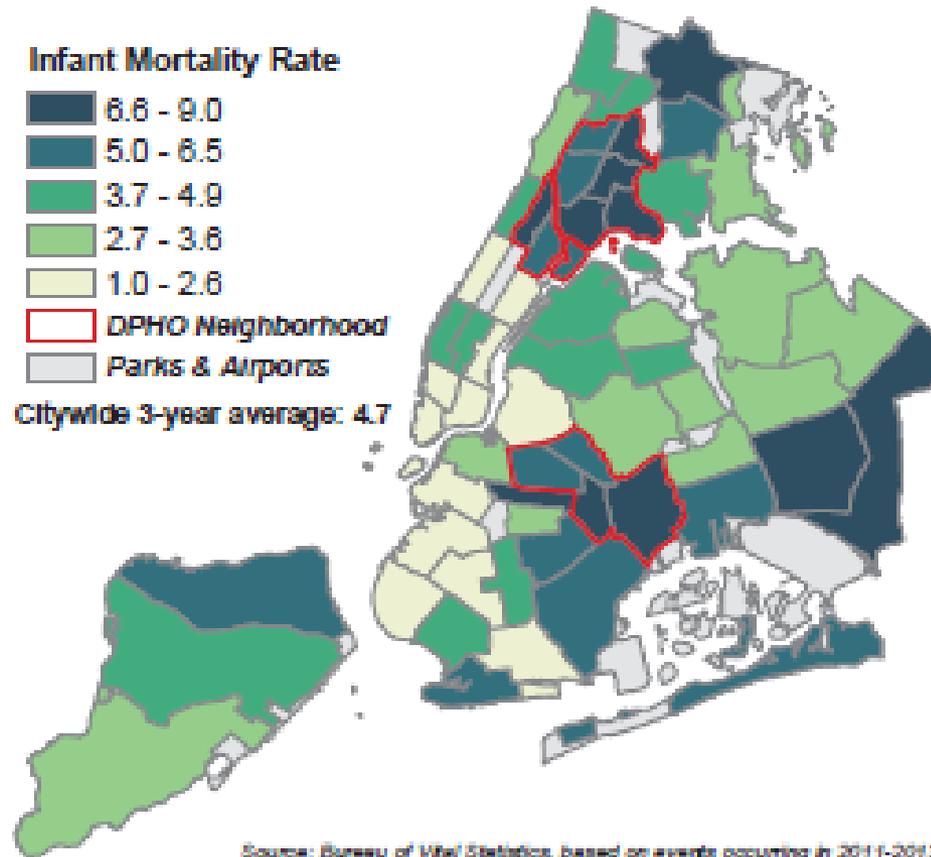


## NYC Agency Collaboration for Safe Sleep

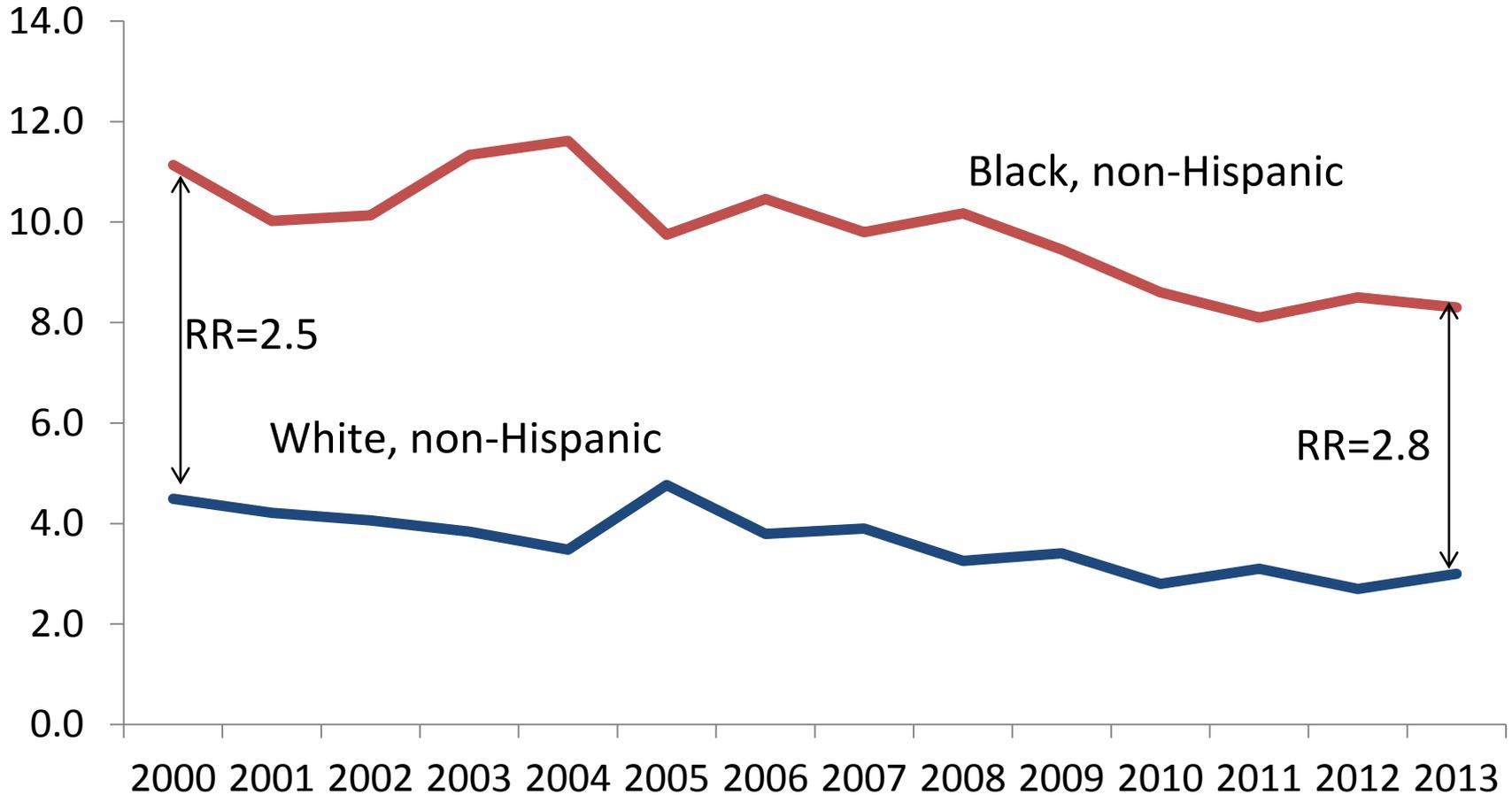
# Understanding Infant Fatalities & Unsafe Sleep

**Dr. Oxiris Barbot**  
**First Deputy Commissioner**  
**Department of Health & Mental Hygiene**

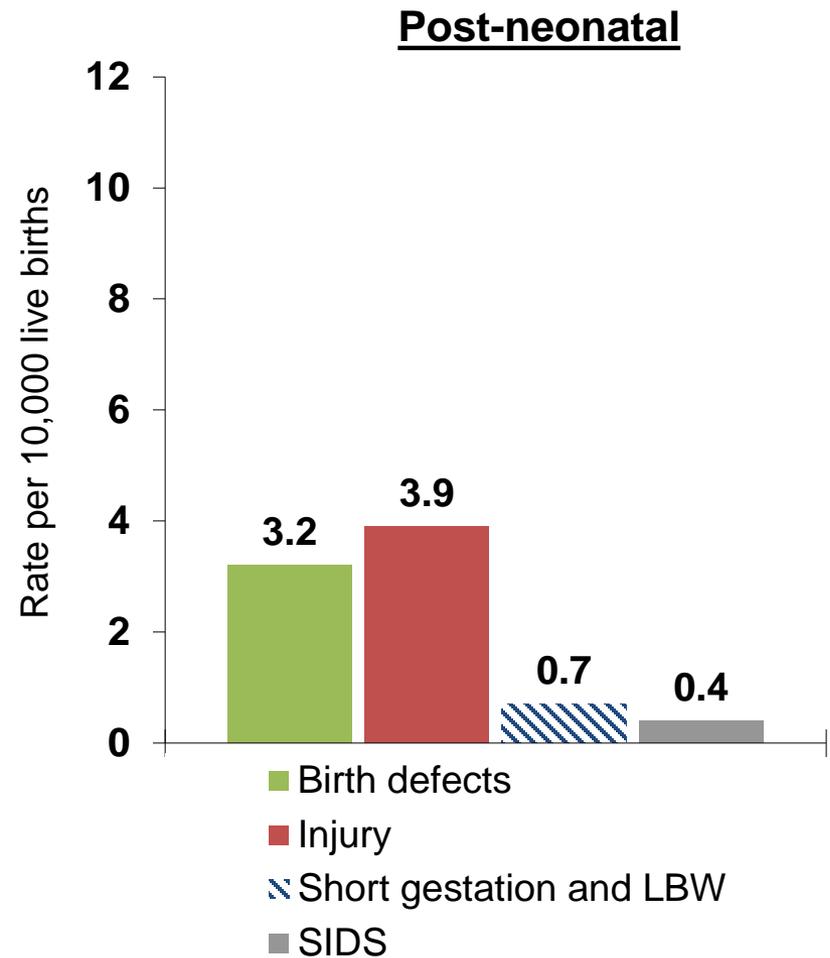
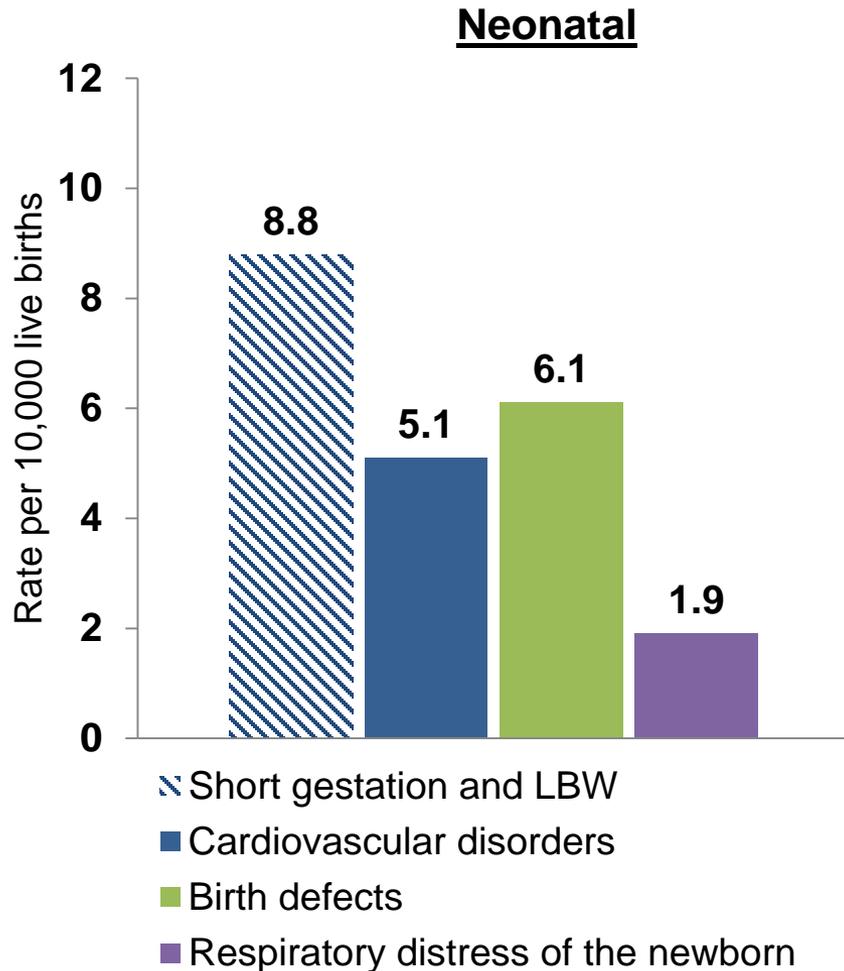
## Geographic Disparities in Infant Mortality NYC 2011-2013



## Differential Decline in Infant Mortality Rate by Race



## Leading Causes of Neonatal and Post-neonatal Death, NYC 2013\*

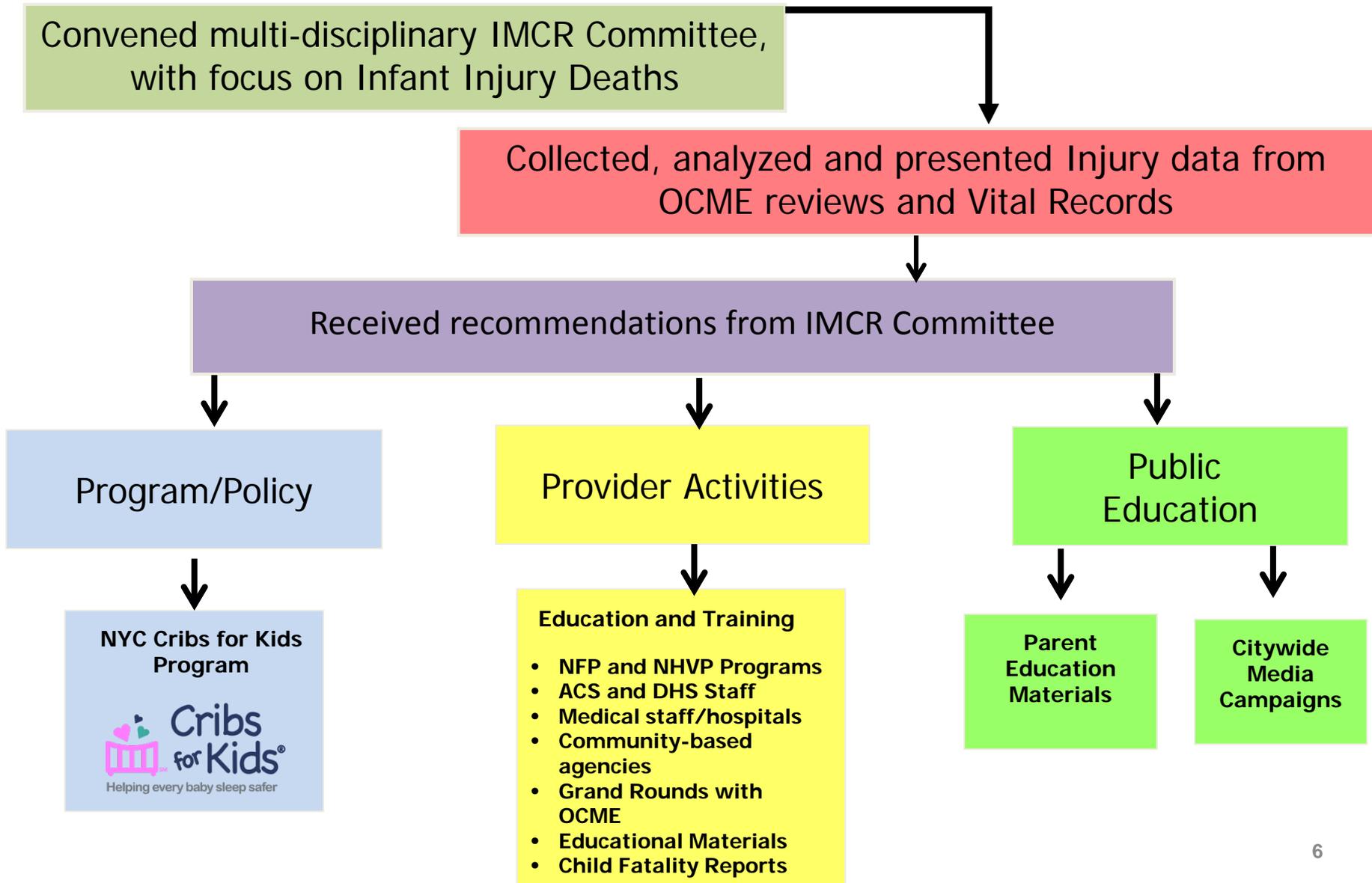


\*Rate per 10,000 live births

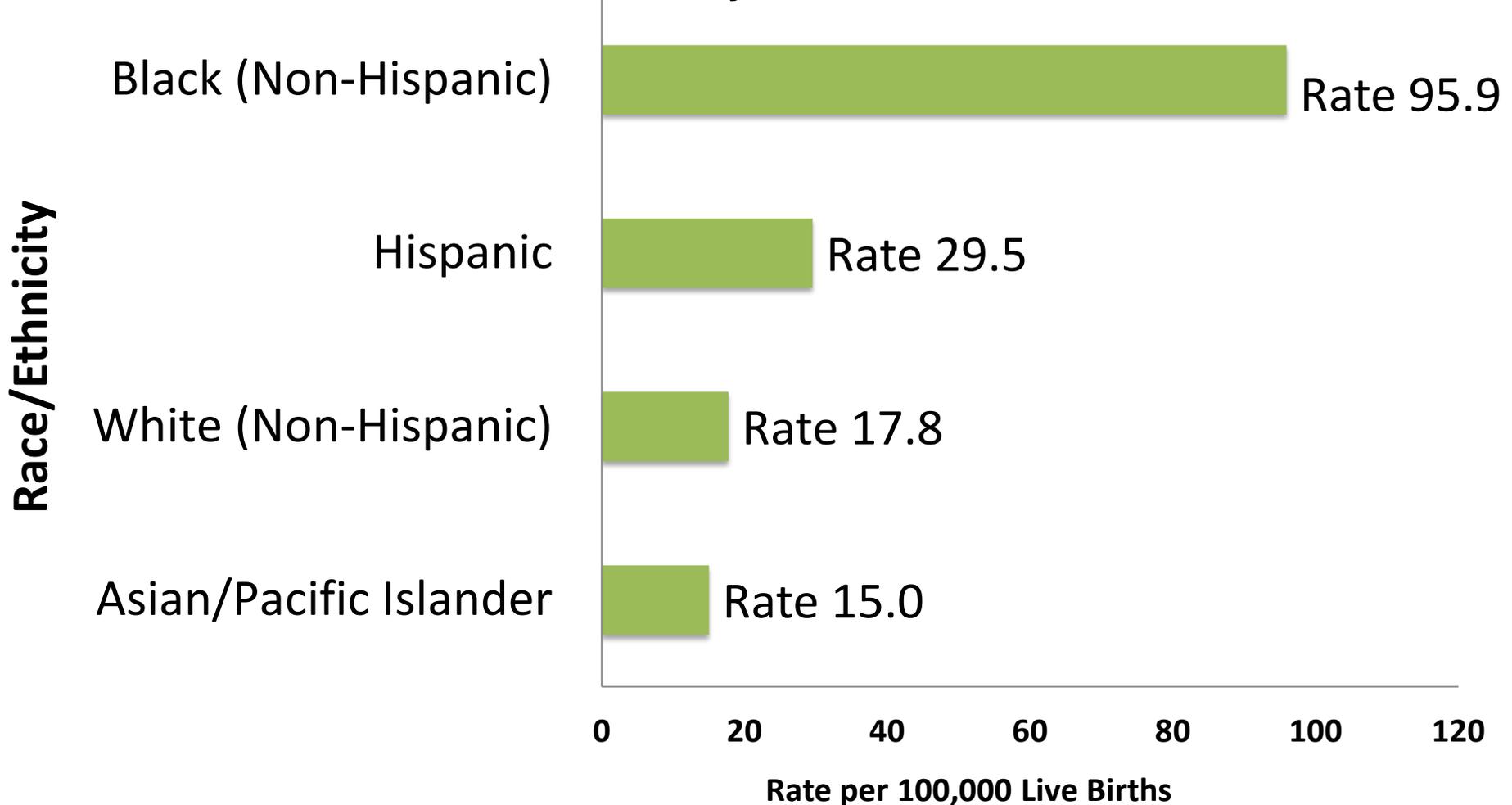
Commission to Eliminate Child Abuse and Neglect Fatalities  
August 6, 2015, New York City

Source: Bureau of Vital Statistics; compiled by BMIRH

# INFANT MORTALITY CASE REVIEW (IMCR) 2005: Using Unintentional Injury Data to Inform Policy, Data Collection, and Education



## Sleep-Related Infant Unintentional Injury Death by Maternal Race/Ethnicity, NYC, 2004-2012



# Characteristics of Sleep-Related Infant Unintentional Injury Deaths in NYC 2004-2012

- 74% were age 28 days through 4 months old
- 40% were sleeping on their stomach compared to 29% on their back
- Nearly 60% were sleeping with excess bedding\*
- 57% were sharing a bed with an adult or a child at last sleep
  - Compared to 28% that were found in a bassinet or crib

\*Source: 2014 BMIRH Preliminary Report, \*\*2013 NYC CFRAT Report

## Public Health Perspective

- Shift the conversation to *Injury Prevention*
  - Parents and providers should receive education on the importance of a safe sleep environment;
    - education should occur prenatally and be reinforced in the early postpartum period to all family members
  - Support families in need by providing the tools for safe sleep
  - Consumer advocacy for modeling safe sleep
  - Interagency collaborations are needed for consistent messaging and practices

## Collaboration Among NYC Government Agencies

- Office of Deputy Mayor for Health and Human Services
- Office of Emergency Management (OEM)
- Administration for Children Services (ACS)
- Health and Hospitals Corporation (HHC)
- Human Resources Administration (HRA)
- Department of Homeless Services (DHS)
- NYC DOHMH

# Safe Sleep Campaign Strategy

**Dr. Jacqueline McKnight**  
**Executive Deputy Commissioner, Child Welfare Programs**  
**Administration for Children's Services**

## ACS Data: Fatalities/Total Investigations

Calendar Year	Total # of Children in SCR Investigations	SCR Fatality Reports	Fatalities as Percent of Total Children in Investigations
2010	93,834	82	0.09%
2011	90,714	78	0.09%
2012	85,759	91	0.11%
2013	83,700	88	0.11%
2014	84,718	100	0.12%

## Majority of Fatalities Related to Unsafe Sleep

Year	Total Number of Panel Fatalities*	Number/Percent of Panel Fatalities Related to Unsafe Sleep
2010	45	18 (40%)
2011	43	18 (41%)
2012	50	19 (38%)
2013	44	21 (48%)
2014	58	19 (33%)

\*Panel fatalities are child deaths that occur in families known to ACS

# ACS Safe Sleep Unit



Child Welfare Programs



- ACS is hiring a team of seven staff to plan, manage, and implement our strategies
- 5 Community Coordinators will work in targeted neighborhoods with high rates of unsafe sleep deaths such as Central Brooklyn and Morrisania in the Bronx to educate families about safe sleep practices

# NYC Safe Sleep Campaign Strategy

- Ensure a unified safe sleep message across all health and human services agencies and contracted providers
- Produce a 30 second Public Service Announcement
- Targeted outreach to new parents (e.g. child care programs, hospitals, and shelters)
- Specialized training curriculum for staff
- Coordinate efforts to collect/use data for informing strategy



**STAY CLOSE. SLEEP APART.**

**Your baby sleeps safest alone**  
on her back in a crib or bassinet free of toys,  
blankets and pillows.

**EVERY YEAR ABOUT 50 BABIES IN NYC DIE FROM A SLEEP-RELATED INJURY.**

To learn more, call 311 or visit [nyc.gov](http://nyc.gov)  
and search "infant safety"

**NYC** Department of Health & Mental Hygiene Administration for Children's Services  
100 10th Avenue, 10th Floor, New York, NY 10014-1598

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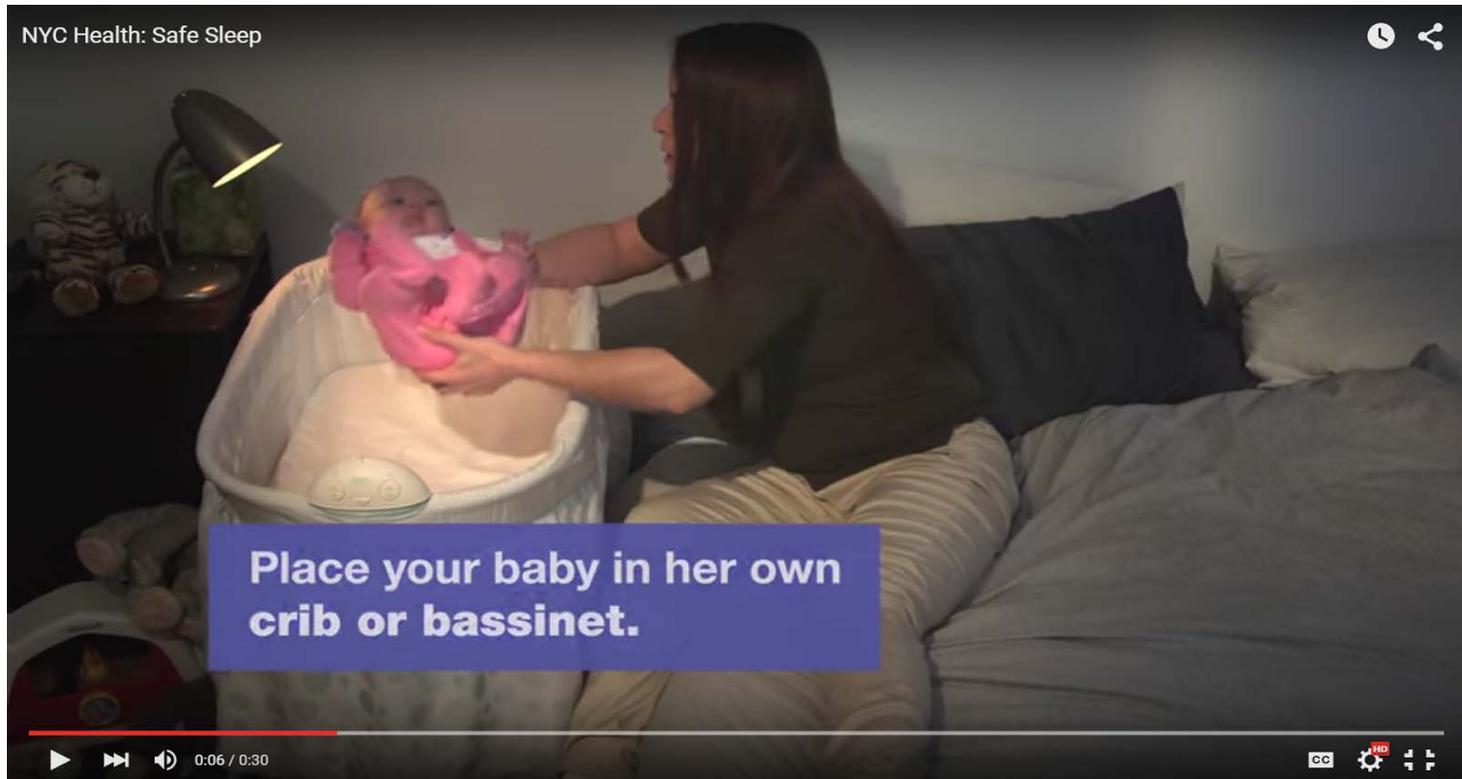
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## 30 Second PSA



Produced in Spring 2015 and viewed over 150,000 times on YouTube



  
**Infant Safe Sleep  
Training**

**TIPS**

- Always place a baby in a crib to sleep
- Never bed share with a baby
- No soft bedding in baby's sleep area
- Never smoke around baby
- Provide supervised Tummy Time
- Always place baby on back to sleep
- No toys or other objects in baby's crib

**TIPS**

  
**Infant Safe Sleep  
Symposium**

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- No toys or other objects in baby's crib

# Ensuring Child Safety in Shelter

**Lorraine Stephens**  
**First Deputy Commissioner**  
**Department of Homeless Services**

## Snapshot of Families in Shelter August 2015

11,000+ Families in DHS Shelters

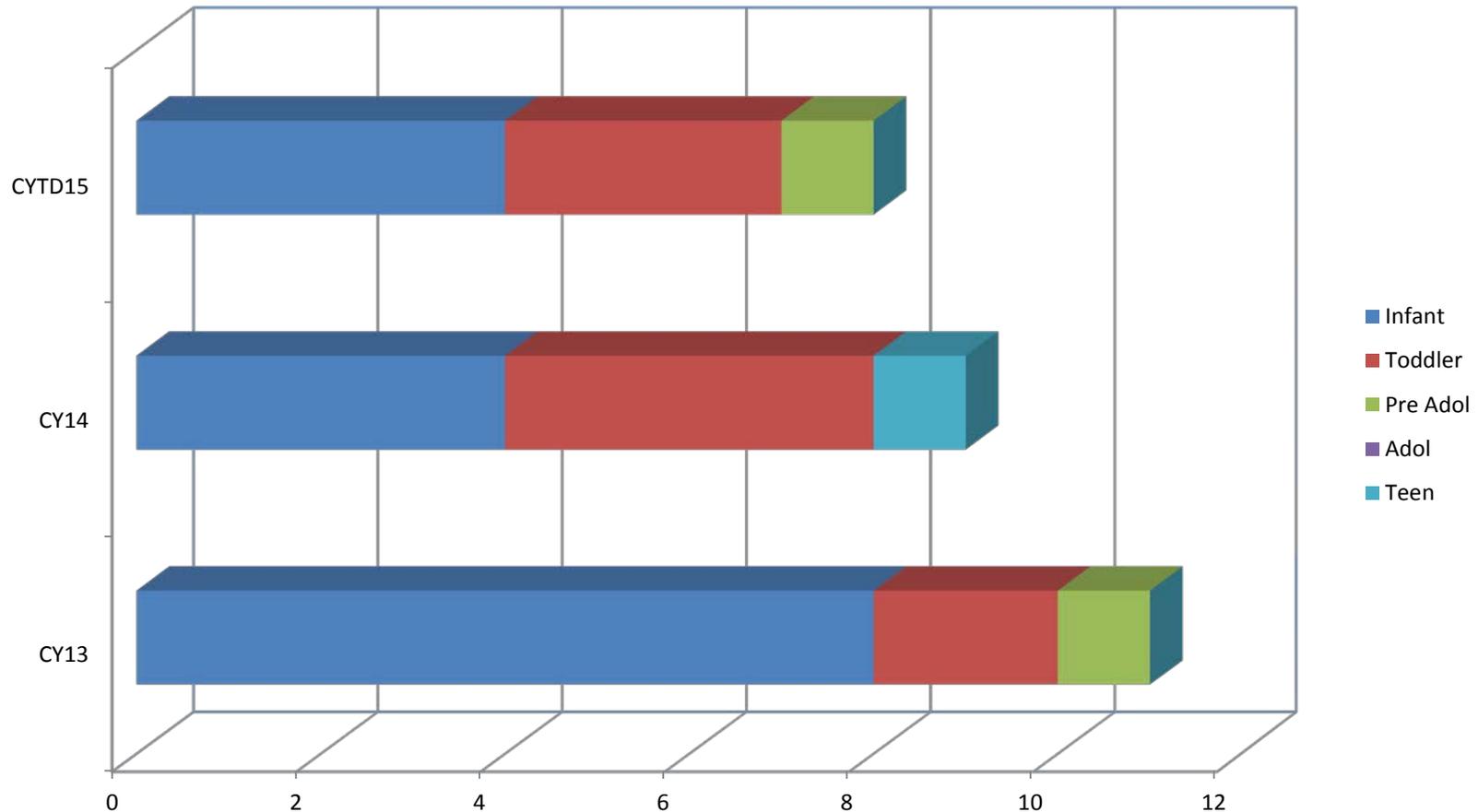
### Adults

- Family Composition
  - Average Number of adult 1:3
  - In shelter as a child (18%)
- Age and Gender
  - Average age of head of household (34)
- Education
  - 47% no high school diploma
- Public Assistance
  - Active Case Assistance (83%)

### Children

- Age 0-5
  - 9207 children (40%)
- Age 6-17
  - 12,474 children (54%)
- Age 18-21
  - 1,538 children (7%)
- ACS Child Welfare Involvement
  - 24% have an open case
  - Over 50% of families with an open case have a child younger than 3 years old

## Number of Deaths by Age Group CY 13 – CYTD 15



***Majority of fatalities involve infants and toddlers***

## **Strengthening Child Safety in Shelters Together**

- **Understanding Our Families**
  - Joint Case Record Review Initiative with ACS
  
- **Bolstering Identification of High Risk Families**
  - ACS units at shelter intake that perform maltreatment clearances
  - Establishing additional ACS units to help make assessments
  - Identifying children with high risk medical needs
  
- **Developing supports for families**
  - Increase engagement with families in shelter (e.g. visits)
  - Hired team of social workers who have met with 2500 families
  - Linking families to early child care services and preventive services

# Safe Sleep Outreach

## At Intake

- Visits with Health Educator
- Offered DOHMH Nurse Family Partnership
- Show child safety/safe sleep videos
- Safe Sleep Brochures

## In Shelter

- Provided with a Crib for all Children Under 2 years and ensure their use
- Safe Sleep Signage in shelters
- Safe Sleep Practices Training for Shelter Staff
- Mandated Reporter Training for Shelter Staff
- Infant Safety Protocols

# New York City's Instant Response Team Protocol

AN INTERDISCIPLINARY APPROACH TO CHILD ABUSE  
INVESTIGATIONS THROUGH EXPERT COORDINATION

# Creation of Instant Response

- Developed Jointly Between ACS and NYPD After a High Profile Fatality
- First IRT – May 5, 1998
- Historically Approximately 4-6% of All Cases Are Handled as an IRT
- Either Agency Can Trigger an IRT

# The Mission

of the Instant Response Teams is to improve coordination between Child Protective Services (CPS) and Law Enforcement in order to enhance the protection of children in New York City.

In cases involving **severe abuse and severe maltreatment** committed by a parent or person legally responsible, personnel from CPS, Law Enforcement, and the District Attorney's Offices (DA) work together on "Instant Response Teams" in order to accomplish the following objectives:

# Goals: Improve Investigations

1. Minimize trauma to the child(ren) during the investigation process by:
  - Reducing the need for repetitive interviewing by law enforcement, medical and social service staff,
  - Holding interviews and medical examinations in child-friendly surroundings, such as Child Advocacy Centers.
2. In a timely, effective, and coordinated manner:
  - Respond Jointly
  - Gather evidence
  - Remove the alleged abuser instead of the child(ren) when appropriate

# Instant Response Teams

- All fatalities reported to the SCR
- Severe physical abuse
- Sexual offenses
- Rape, sodomy, or forcible sexual abuse
- Severe maltreatment of children  
(Malnutrition/Failure to Thrive)
- Any investigation that benefits from a multi-disciplinary response

# Triggering the IRT:

## The Role of the IRT Coordinator

- Screening of Incoming Cases
- Contacting the Source
- Coordinate Transportation for CPS Workers
- Coordinating With Child Advocacy Centers

# Instant Response Teams

- Hotline –

1-877-Call IRT

- This Smartphone is Manned 24 Hours a Day and is Law Enforcement's Link to Information and a Rapid Response

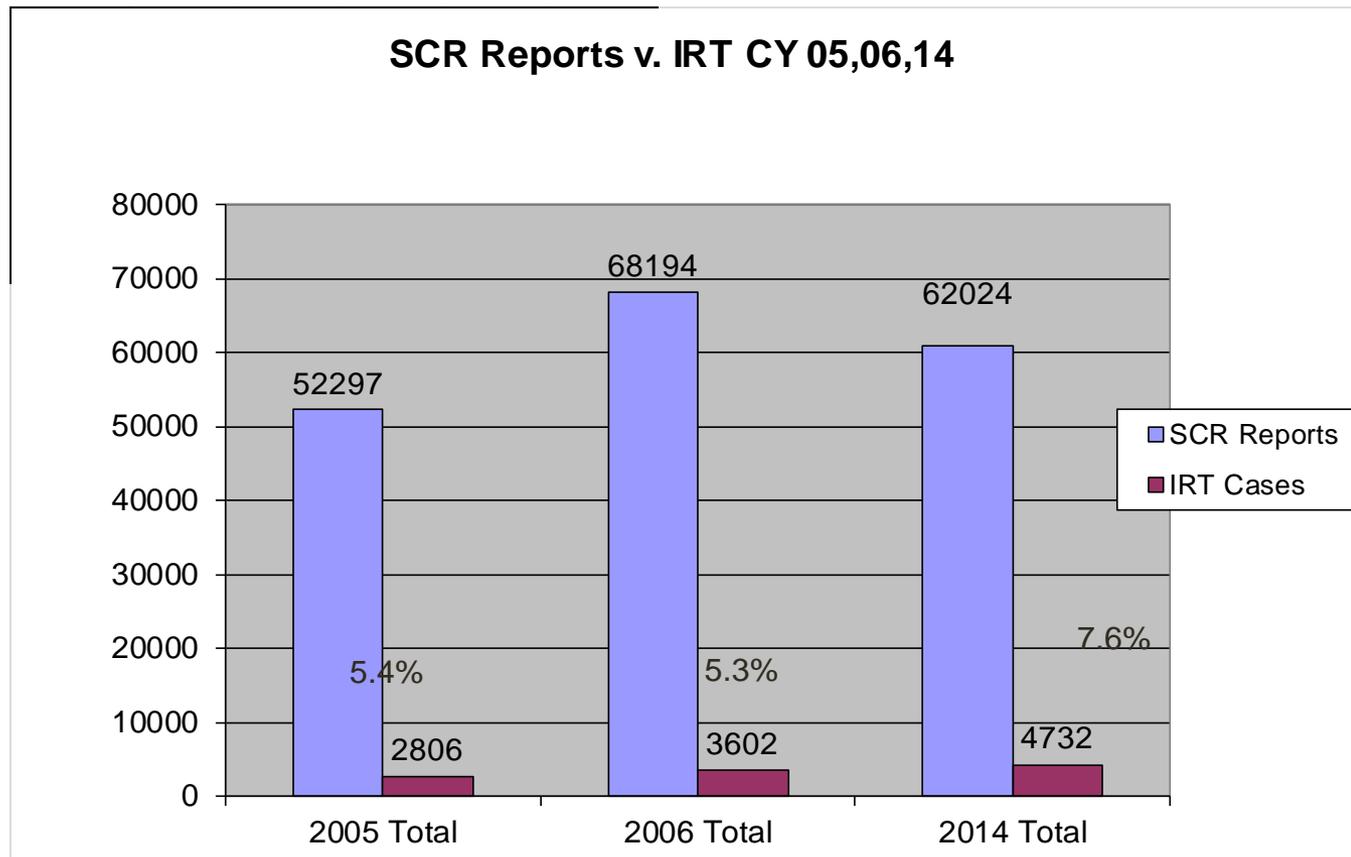
# How Cases Are Identified

- SCR Initiated – The case that comes to ACS via the SCR that meets IRT criteria
- CPS Initiated - The case that comes to ACS via the SCR that initially does not meet IRT criteria
- Police Initiated – The 911 call that meets the IRT criteria
- NYPD Assistance Calls – Requests for police assistance (Radio Code 10-68A)
  - Warrants
  - Entry orders
  - Removals
  - Safety issues

# IRT Enhancements:

- Creation of the NYPD IRT Unit - 2006
- The IRT Application (IRTA)
  - A Database that is used to relay Information from One Agency to the Other
  - Collects Data
  - Produces Reports

# Citywide IRT Data



# The Investigative Consultation Program

# Established In November, 2006

The Investigative Consultants, all of whom came to ACS with over 20 years of prior service in law enforcement, were hired to enhance the investigation process.

# Their Experience

All have experience in conducting criminal investigations; specifically in the fields of:

- Child Abuse
- Domestic Violence
- Special Victims/Sex Crimes
- Homicide
- Missing Persons
- Narcotics
- Warrant Squad

# Their Role

The Investigative Consultants are assigned to all of the borough offices located throughout the city.

- Help child protective staff enhance their investigative skills both in the office and in the field,
- Provide investigative advice to CPS on cases
- Assist CPS in obtaining information from law enforcement agencies
- Provide onsite training regarding investigative techniques

# How Databases Help Us

- Identify children and families
- Locate children and families
- Provide CPS with an analysis of criminal and domestic violence history to assist them in their ongoing assessment of safety and risk to children

# Interactions With Law Enforcement:

- Help Locate Missing Children and Family Members
- Help Identify CSEC Youth
- Responding on Fatalities and High Profile Cases With CPS
- Serve as a Bridge to Law Enforcement
- Partnership With The Sheriff's Office

# Statistics:

In calendar year 2014, the total number of investigative consultations conducted was **64,570.**

In 2014, the ICs conducted the following investigative actions:

- Assisted CPS in locating 3,579 persons including **2,201** children.
- 28.07% of the persons analyzed had a criminal history.
- 57.67% of these persons had a domestic violence history.
- Assisted in accurately identifying 27,009 persons.

# Contact Information

- Susan Morley, Senior Advisor For Investigations
- Phone: 212-341-0947
- Email: [susan.morley@acs.nyc.gov](mailto:susan.morley@acs.nyc.gov)

# New York City's Instant Response Team Protocol

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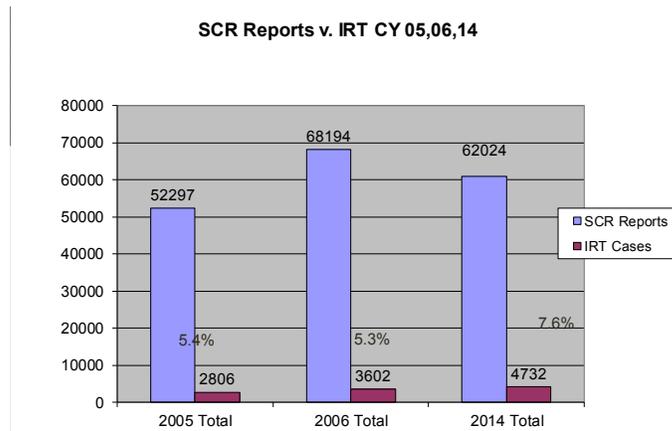
[ 8 ]

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## Citywide IRT Data



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# The Role of Clinical Consultation in Child Welfare Practice

CECANF Presentation August 6, 2015

# Background

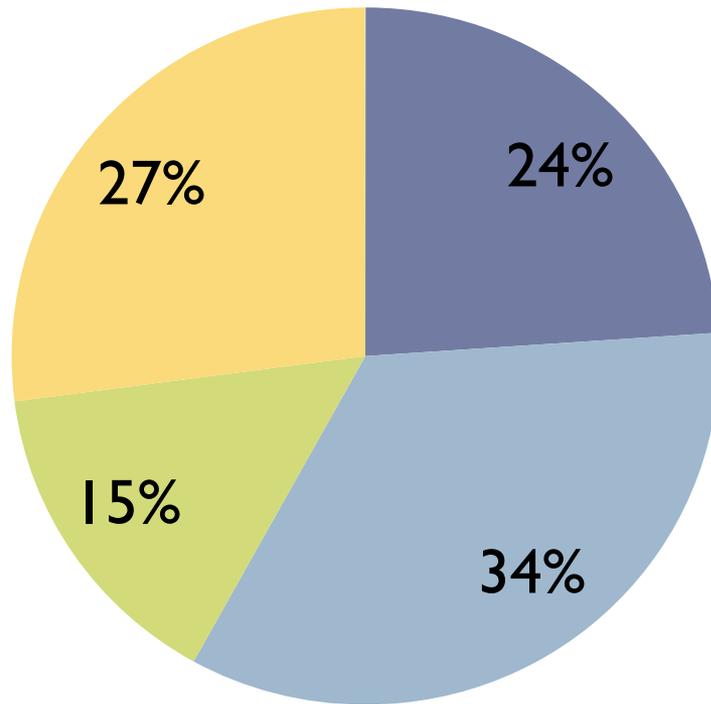
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- ▶ Launched in 2002 out of a need identified by the Accountability Review Panel to improve casework practice and decision making to front line staff on cases presenting with clinical concerns
- ▶ Clinical expertise and support to Child Protection Specialists in the investigative stage to address:
  - ▶ Domestic Violence
  - ▶ Mental Health
  - ▶ Substance Use
  - ▶ Medical

# 2014 Consultations

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■ DV ■ Medical ■ Substance Use ■ Mental Health



# What Does a Consult Look Like?

---

- ▶ Domestic Violence Consultation
  - ▶ Case is called into the SCR with an allegation of Domestic Violence
  - ▶ Child Protective Specialist (CPS) worker requests Domestic Incident Reports (DIRs) and criminal background information from Investigative Consultants
  - ▶ CPS requests a consult from a Domestic Violence specialist
    - ▶ Reviews DIRS
    - ▶ Identifies patterns of abuse, including coercive and controlling behaviors
    - ▶ Models best practice using a trauma focused lens
    - ▶ Recommendations for safety planning and service referrals
  - ▶ Death of parent as a result of DV is the subject of too many of our cases.

# Medical Consultations

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- ▶ Nurse Practitioners that are supervised by a doctor at Bellevue hospital who is a leading expert in child abuse injuries
- ▶ Medical conditions and child care needs can increase risk
  - ▶ About the condition
  - ▶ Care needs of the condition
  - ▶ Impact of the condition if not addressed
  - ▶ Parents ability and willingness to provide the care
- ▶ What supports are in place to assist the family?
- ▶ Medical consultation can play a role in preventing serious injury or fatality

# Mental Health Consultation

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- ▶ Mental health issues are identified in at least 25% cases that come to ACS's attention
- ▶ Families have complex needs. Consults include:
  - ▶ Acuity of presenting symptoms and how may impact parenting
  - ▶ Duration and intensity of concerning behavior
  - ▶ Co-occurring disorders
  - ▶ Diagnosis
  - ▶ Support system
  - ▶ Medication maintenance
  - ▶ Counseling services
  - ▶ Stressors on the family system

# Substance Use Assessments

---

- ▶ CASACs meet directly with clients at the first point of entry into the system
- ▶ Assess level of drug and/or alcohol use with an evidence based screening tool
- ▶ Make referrals and treatment recommendations
- ▶ Some CASACs offer individual and group services in the borough offices

# Purpose of Consultations

---

- ▶ Provide a clinical lens to casework practice
- ▶ Identify “red flags” or issues of concern that can impact the safety and well-being of a child
- ▶ Referral information
  - ▶ Mental health, domestic violence, medical specialists, substance use services, bereavement
- ▶ Participation in child safety conferences
- ▶ Crisis debriefing
- ▶ Office based training to the Division of Child Protection staff

# Contact Us

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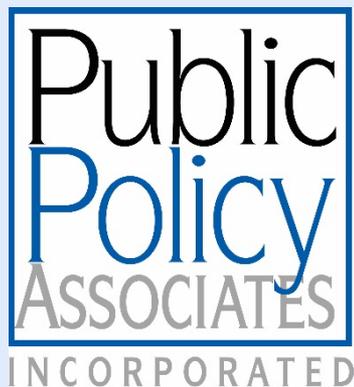
Andrea Goetz, LMSW  
Assistant Commissioner  
Office of Clinical Practice, Policy and Support  
Administration for Children's Services  
212-442-4132  
Andrea.Goetz@acs.nyc.gov





# COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

## Identifying and Reducing Disproportionate Minority Contact in the Child Welfare System: A Retrospective Look at Michigan's Efforts



**Paul Elam, Ph.D., President**

New York Public Meeting

Thursday, August 6, 2015

8:00 – 5:30 p.m. EDT

ACS Children's Center – Auditorium

492 First Avenue at 28th Street, New York, NY 10016

# Public Policy Associates, Inc.

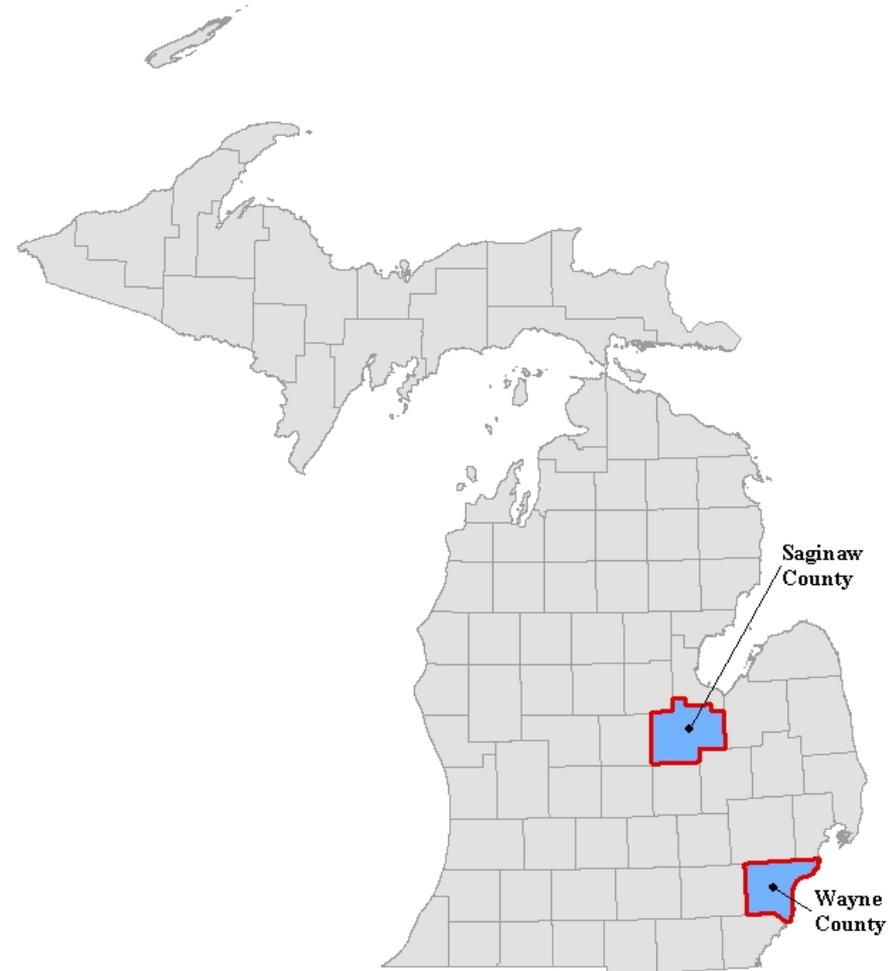
- Public Policy Associates, Inc. provides clients with the research and strategic consultation they need to make smart public policy decisions that improve lives, enrich communities, and strengthen institutions.
- Help clients achieve smart public policy decisions by providing:
  - Rigorous research and evaluation
  - Insightful interpretation
  - Strategic planning and consultation
  - Technical assistance and training
  - Program management

# Background

- Working with the Governor's Committee on Juvenile Justice, the Michigan Department of Health and Human Services, the Michigan Supreme Court, and local jurisdictions to ensure that system-involved youth are treated fairly and equitably.
- Provide technical assistance and strategic support to develop and implement solutions that promote the safe detention of juveniles in adult facilities and reduce disproportionate minority contact in the child welfare and juvenile justice systems.

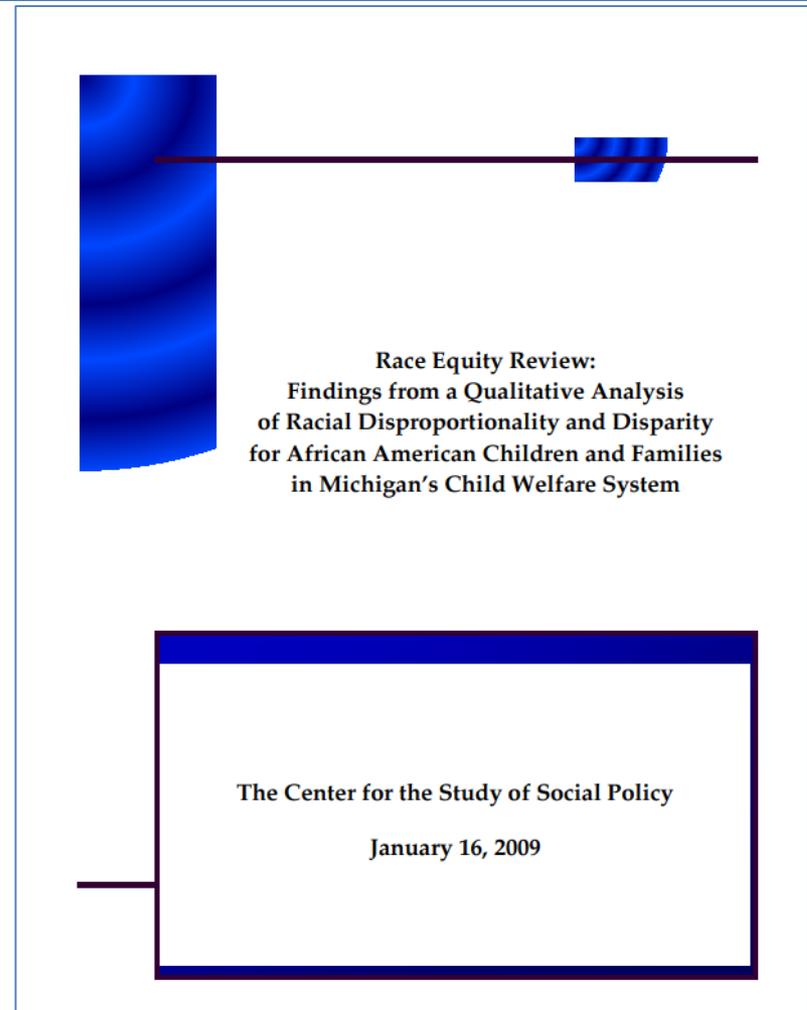
# History and Context: 2007

- Race equity review in Saginaw and Wayne counties
- Qualitative findings of disproportionate outcomes and disparate treatment



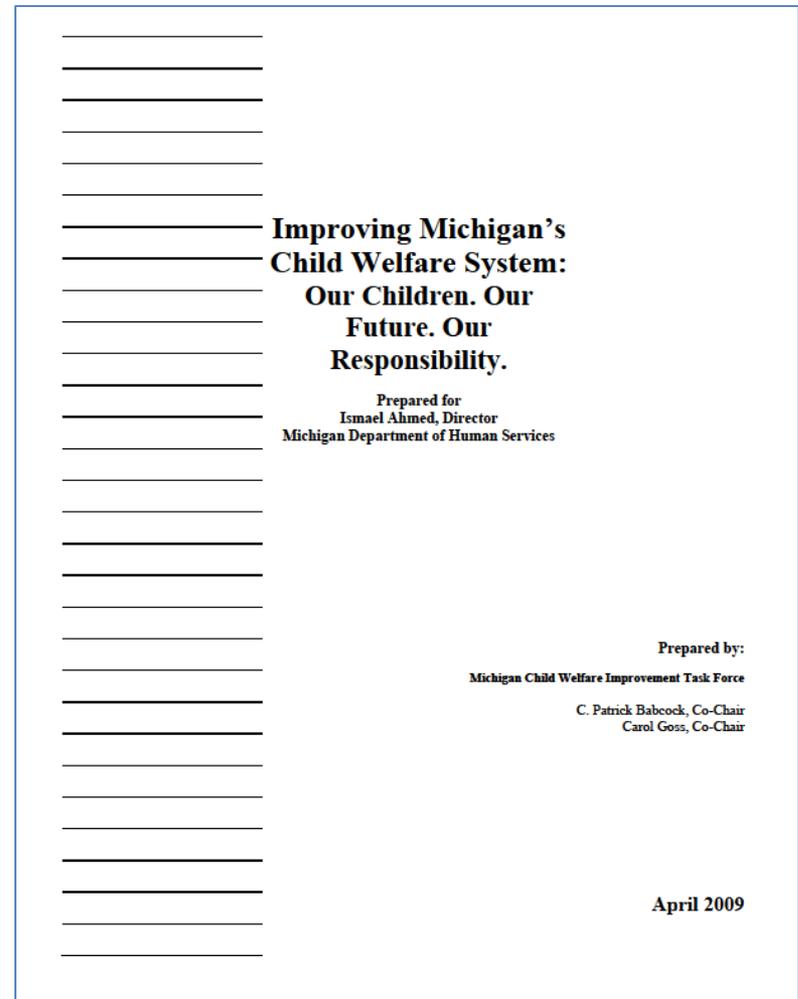
# History and Context: 2008

- Report released documenting racial disproportionality and disparity for African American children and families in Michigan's Child Welfare System
- Michigan Department of Health and Human Services not supportive of the findings



# History and Context: 2008

- Michigan Child Welfare Improvement Task Force Established
- Recommendation: Racial, gender and cultural equity must become a priority for the child welfare system



# History and Context: 2009

- Michigan Race Equity Coalition Established
- Racial, gender and cultural equity must become a priority for the child welfare system



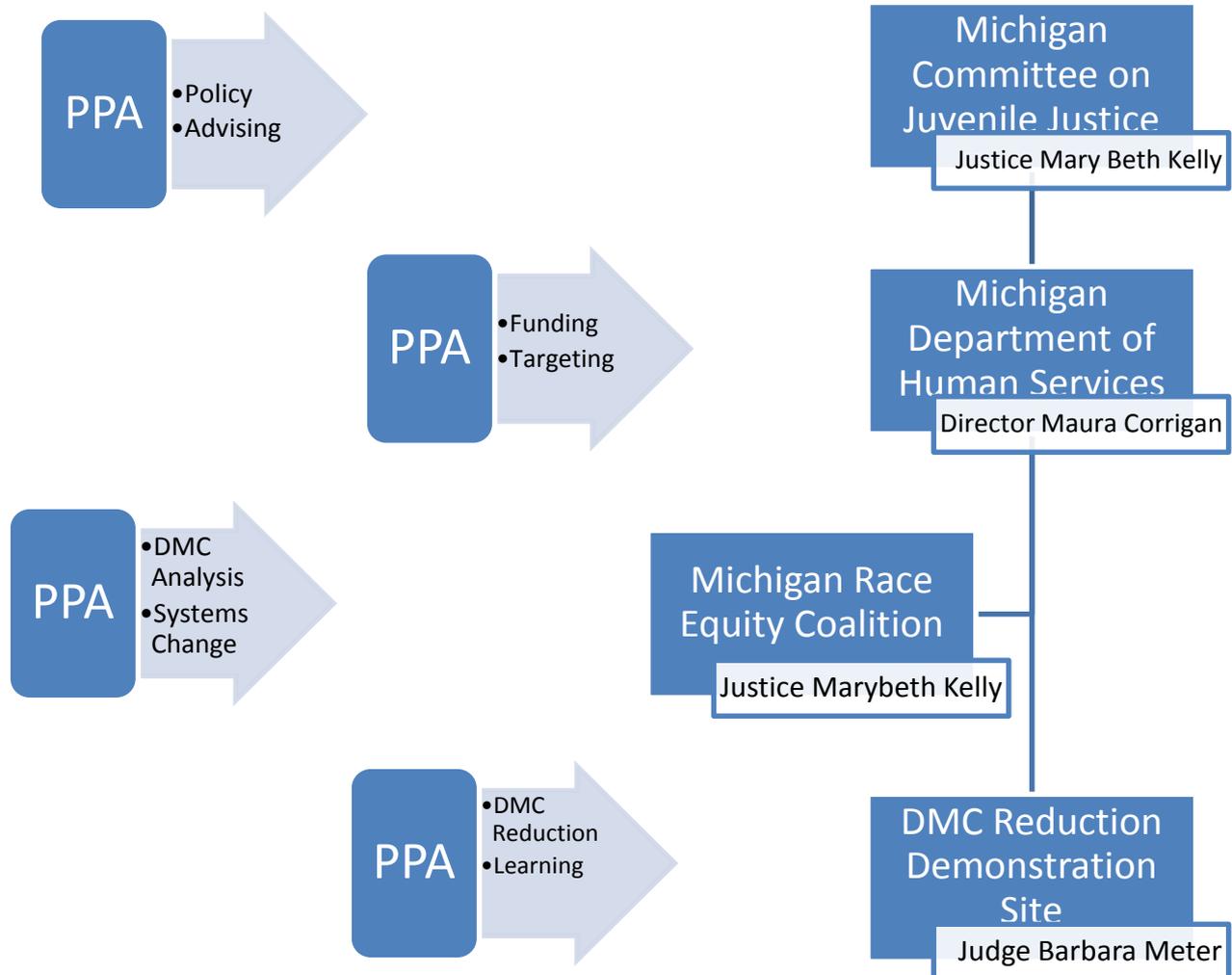
Michigan Race Equity Coalition:  
Child Welfare and Juvenile Justice

May 21, 2014

# Michigan Race Equity Coalition Charge

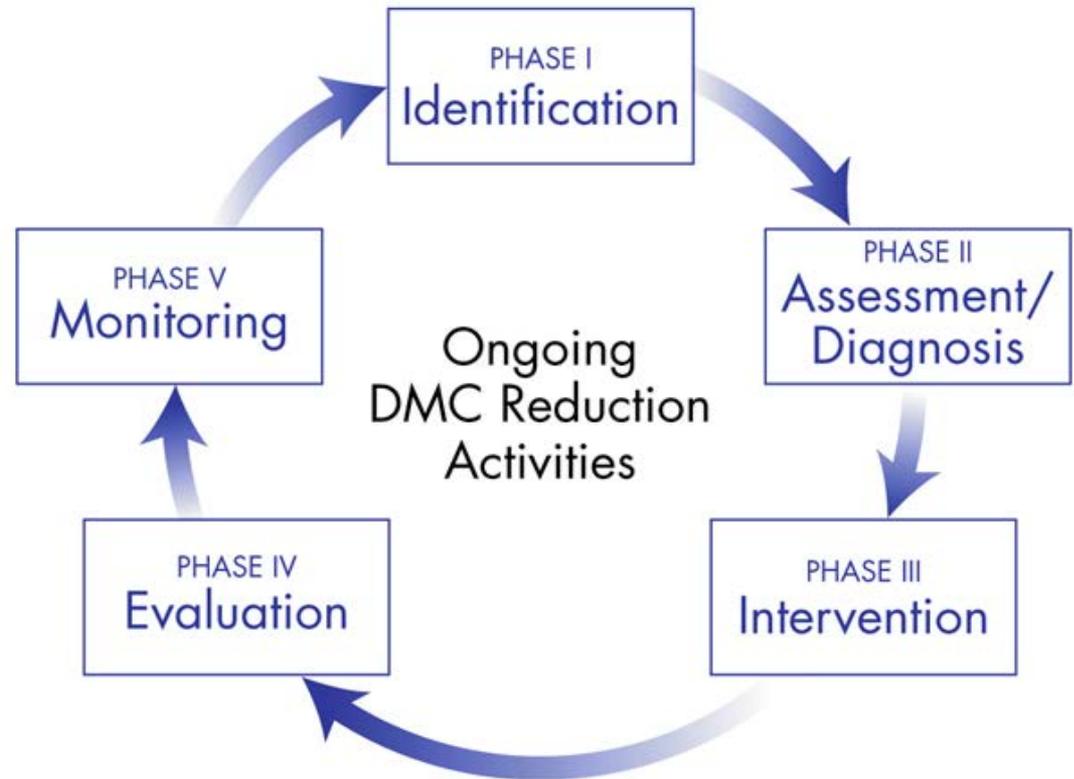
1. Establish and convene a state-wide coordinating body to oversee efforts to reduce racial disproportionality in Michigan's child welfare and juvenile justice systems
2. **Identify key decision points in the child welfare system that contribute to disproportionality**
3. Create systems to collect state and local data at every decision point of contact that youth may have with the child welfare system to identify where disproportionalities exist and the causes of those disproportionalities
4. **Develop and implement plans to address racial disproportionalities that include measureable objectives for policy or practice change**
5. Review the evaluation results to determine the impact of implemented actions to reduce disproportionalities in the child welfare system
6. Monitor and annually report findings and progress on efforts to reduce disproportionalities

# Strategic Leadership and Coaching



# DMC Reduction Model

- State-Level
  - Leadership
  - Accountability
  - Policy
- Local-Level
  - Implementation
  - Learning
  - Underlying causes



# Mechanisms Leading to DMC

## Differential Behavior

- Differential Offending
  - Seriousness of offenses
  - Recidivism

## Differential Processing

- Differential Handling
  - Decision making
  - Discretion
  - Cultural competence/interpretation of language and behavior

## Other Factors

- Mobility
- Socioeconomic status
- Multiple risk factors
- Race/ethnicity
- Prevention and treatment opportunity
- Geography
- Legislation/policy

# Child Welfare Decision Points

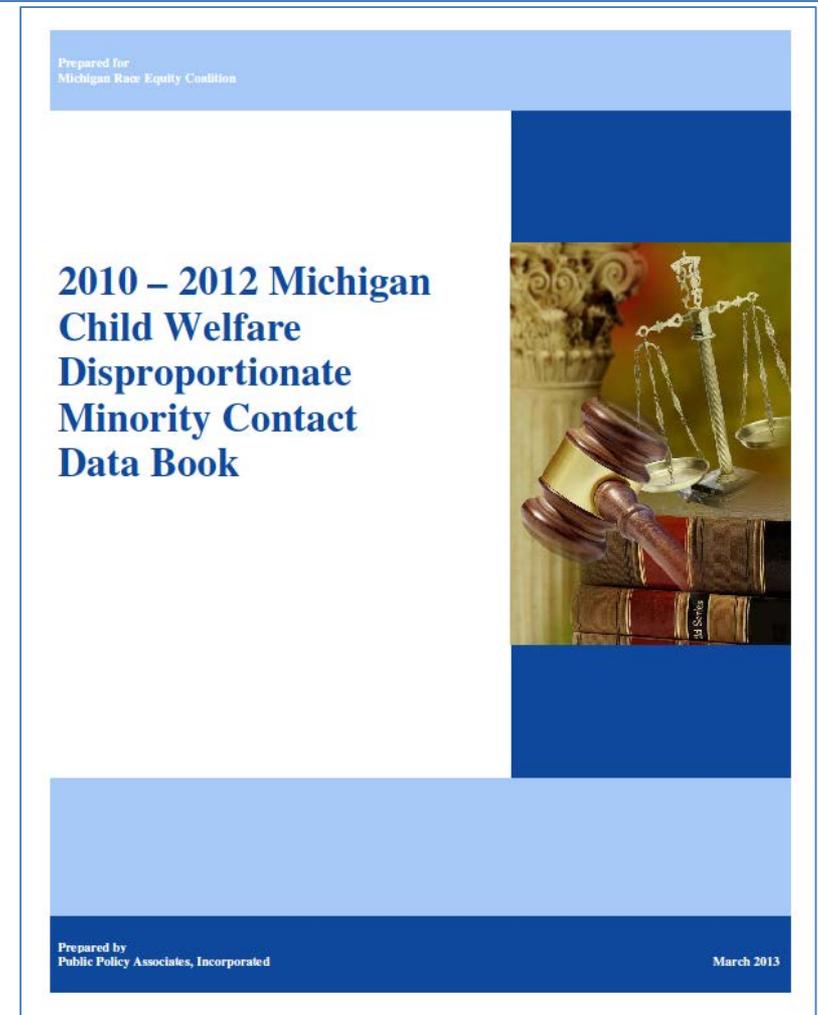
- The Michigan Race Equity Coalition (REC) identified five major decision points with subcategories for DMC analysis.
- Tracked data since calendar year 2010

## Decision Points

1. Assignment
- 2a. Category 1 Disposition
- 2b. Category 2 Disposition
- 2c. Category 3 Disposition
- 2d. Category 4 Disposition
- 2e. Category 5 Disposition
3. Out of Home Placement
4. Termination of Parental Rights
- 5a. Exit Foster Care: Permanent Adoption
- 5b. Exit Foster Care: Aged Out
- 5c. Exit Foster Care: Death
- 5d. Exit Foster Care: Permanent Guardianship
- 5e. Exit Foster Care: Relatives
- 5f. Exit Foster Care: Reunification

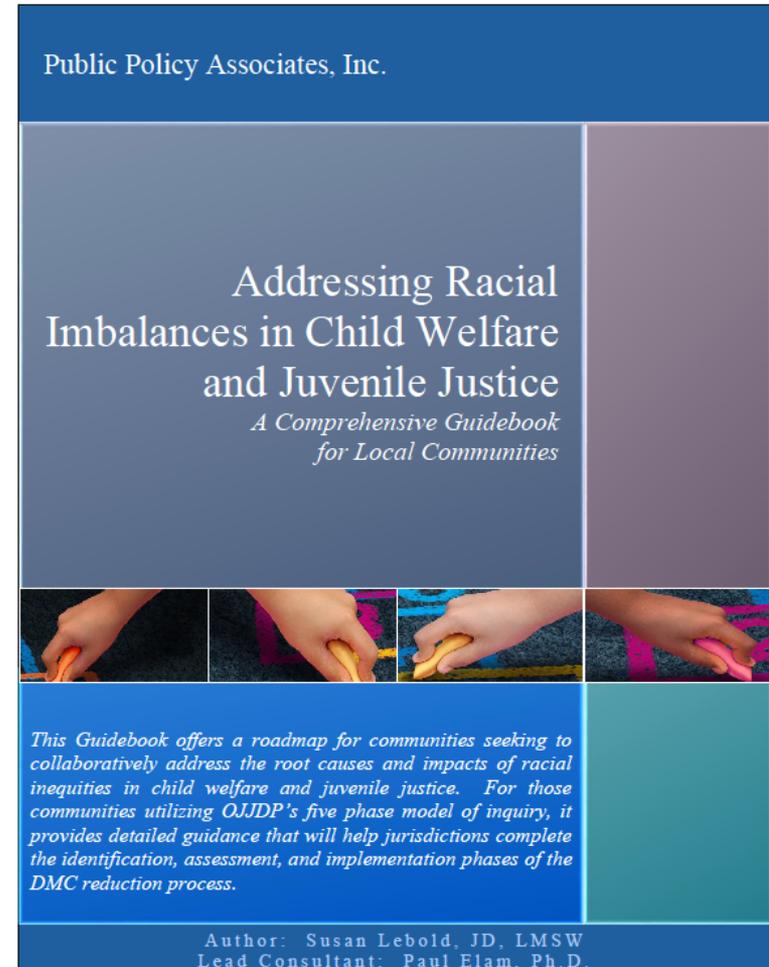
# Developed Statewide and Local DMC Data Books

- This data book contains a table that summarizes how different racial groups moved through the child welfare system.
- The tables show three things:
  - The number of juveniles at each of the decision points
  - The relative rate index (RRI) for that decision point
  - Whether that RRI is statistically significant.



# Developed DMC Reduction Guidebook

- Offers a roadmap for communities seeking to collaboratively address the root causes and impacts of racial inequities in child welfare.
- Provides detailed guidance that will help jurisdictions identify, assess, and implement a DMC reduction process.



# Michigan Child Welfare DMC Findings

- Minorities are more likely to be investigated for abuse and neglect.
- Minorities are more likely to be removed from their home.
- Minorities who are removed from their home are more likely to age out of the foster care system.
- Minorities who are removed from their home are more likely to exit from the system due to death.



# Minorities are more likely to be investigated for abuse and neglect.

**Table 1: Assignments for CPS Investigations in Michigan (1/1/13 – 12/31/13)**

Race	Population at Risk (age 0 through 17)	Decision Points	
		Value	RRI
White	1,591,656	155,137	1.00
African American	408,553	65,448	1.64
Hispanic	173,982	11,444	0.67
American Indian	18,919	1,513	0.82
All Minorities	675,214	79,276	1.20
<b>Causes of Disproportionality</b>	<ul style="list-style-type: none"> <li>Inadequate family supports</li> <li>Weak family-support systems</li> <li>Poverty and dangerous neighborhoods</li> </ul>	<ul style="list-style-type: none"> <li>Housing stress and homelessness</li> <li>Lack of positive role models</li> <li>Lack of job opportunities</li> </ul>	
<b>Recommended Solutions for Disproportionality</b>	<ul style="list-style-type: none"> <li>Education to distinguish abuse/neglect</li> <li>Prosecution of false maltreatment reports</li> <li>Increase collaboration among agencies</li> </ul>	<ul style="list-style-type: none"> <li>More agency collaboration</li> <li>Target services to high need areas</li> <li>School social workers</li> </ul>	

# Minorities are more likely to be removed from their home.

**Table 2: Out-of-Home Placements in Michigan (1/1/13 – 12/31/13)**

Race	Population at Risk (age 0 through 17)	Decision Points	
		Value	RRI
White	1,591,656	2,469	1.00
African American	408,553	1,281	1.26
Hispanic	173,982	278	1.38
American Indian	18,919	62	1.63
All Minorities	675,214	1,636	1.30
<b>Causes of Disproportionality</b>	<ul style="list-style-type: none"> <li>Differential treatment based on race</li> <li>Cultural insensitivity and stereotyping</li> <li>Understanding of abuse/neglect laws</li> </ul>	<ul style="list-style-type: none"> <li>Lack of family engagement skills</li> <li>Lack of minority professionals</li> <li>Organizational practices</li> </ul>	
<b>Recommended Solutions for Disproportionality</b>	<ul style="list-style-type: none"> <li>Multicultural training for professionals</li> <li>Utilization of relative placements</li> <li>Adopt person centered planning</li> </ul>	<ul style="list-style-type: none"> <li>Use of family preservation services</li> <li>Services with parental incentives</li> </ul>	

# Minorities who are removed from their home are more likely to age out of the foster care system.

**Table 3: Out-of-Home Placements that Age Out in Michigan (1/1/13 – 12/31/13)**

Race	Population at Risk (age 0 through 17)	Decision Points	
		Value	RRI
White	1,591,656	443	1.00
African American	408,553	534	2.32
Hispanic	173,982	54	1.08
American Indian	18,919	15	1.35
All Minorities	675,214	603	2.05
<b>Causes of Disproportionality</b>	<ul style="list-style-type: none"> <li>Differential treatment based on race</li> <li>Lack of access to reunification programs</li> </ul>	<ul style="list-style-type: none"> <li>Lack of minority professionals</li> <li>Organizational practices</li> </ul>	
<b>Recommended Solutions for Disproportionality</b>	<ul style="list-style-type: none"> <li>Utilization of relative placements</li> <li>Adopt person centered planning</li> </ul>	<ul style="list-style-type: none"> <li>Use of family preservation services</li> <li>Services with parental incentives</li> </ul>	

# Minorities who are removed from their home are more likely to exit from the system due to death.

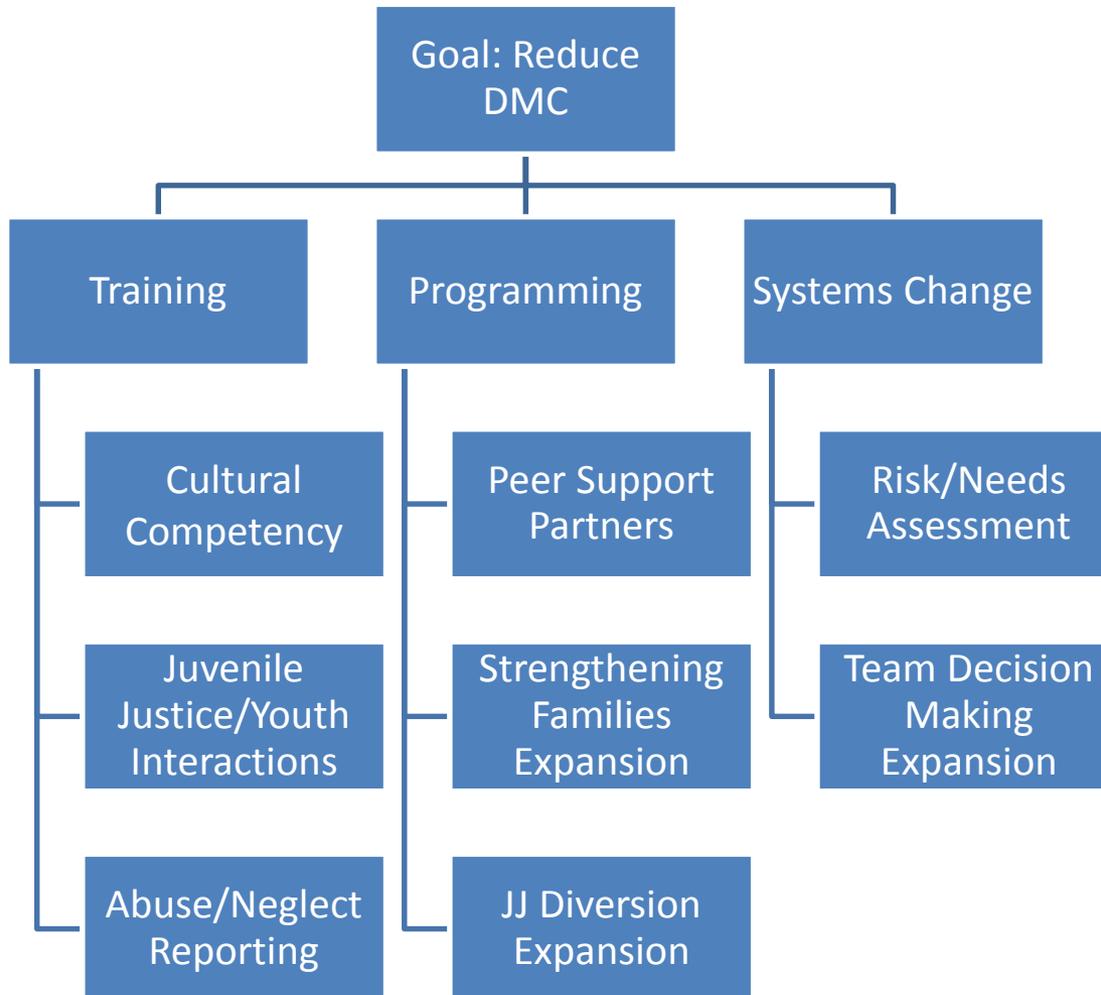
**Table 4: Out-of-Home Placements that Die in Michigan (1/1/10 – 12/31/10)**

Race	Population at Risk (age 0 through 17)	Decision Points	
		Value	RRI
White	1,655,424	9	1.00
African American	426,187	13	2.34
Hispanic	171,847	0	---
American Indian	19,932	0	---
All Minorities	688,644	13	1.93
<b>Causes of Disproportionality</b>	<ul style="list-style-type: none"> <li>• Level of care to keep babies healthy</li> <li>• Sleep-related infant deaths</li> <li>• Drug or alcohol use by care givers who then overlaid their infants during sleep</li> </ul>	<ul style="list-style-type: none"> <li>• Parental neglect and lack of safe sleep practices</li> </ul>	
<b>Recommended Solutions for Disproportionality</b>	<ul style="list-style-type: none"> <li>• Enhance resource awareness</li> <li>• Train school professionals</li> <li>• Train medical professionals</li> </ul>	<ul style="list-style-type: none"> <li>• Train direct service providers</li> <li>• Continue and enhance training</li> <li>• Establish demonstrations</li> </ul>	

# Demonstration Site: DMC Reduction Strategy

- **Dissemination** of assessment findings and public awareness campaigns regarding racial disproportionality in the child welfare and juvenile justice systems.
- **Cultural competency training** for systems leaders, service providers, and frontline staff.
- Family and youth of color engagement **training for law enforcement** (focus on communication, history of mistrust, and alternative response resources).
- **Community outreach programs** between law enforcement and families and youth of color.

# Demonstration Site: DMC Reduction Strategy



# Funding Partners

- Saginaw County Community Mental Health - Substance Abuse and Mental Health Services Administration (Implementation)
- Michigan Department of Health and Human Services - Casey Family Programs (Data Book)
- Michigan Committee on Juvenile Justice – Office of Juvenile Justice and Delinquency Prevention (DMC Reduction Model)

# Current Outcomes

- Data driven decision making
  - Targeting decision points
  - Targeting jurisdictions with limited resources
- System leaders are collaborating
- Increasing multicultural knowledge and culturally responsive practice
- Youth and family engagement
- Addressing underlying causes of abuse and neglect

# Challenges

- Sustaining data collection and data lag
- Capturing accurate data for Hispanic/Latino populations
- Maintaining momentum and commitment during changes in administration
- Securing local and state funding



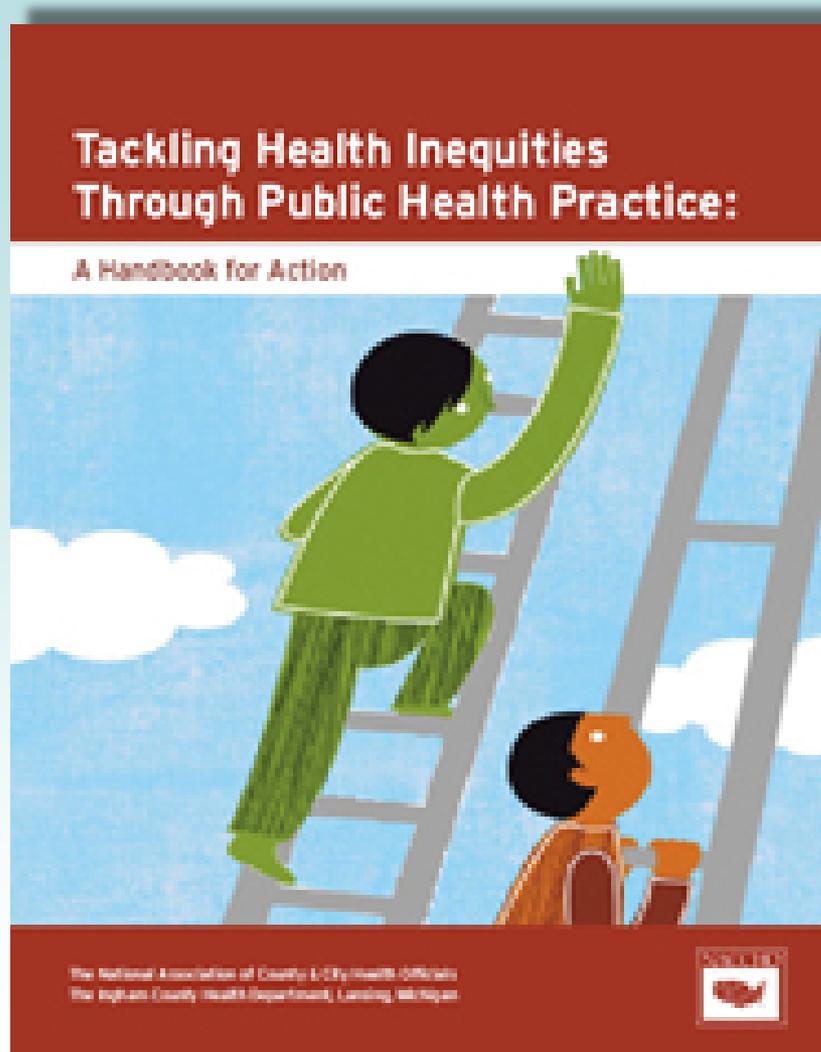
**Paul Elam, Ph.D.**

**President**

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[www.publicpolicy.com](http://www.publicpolicy.com)

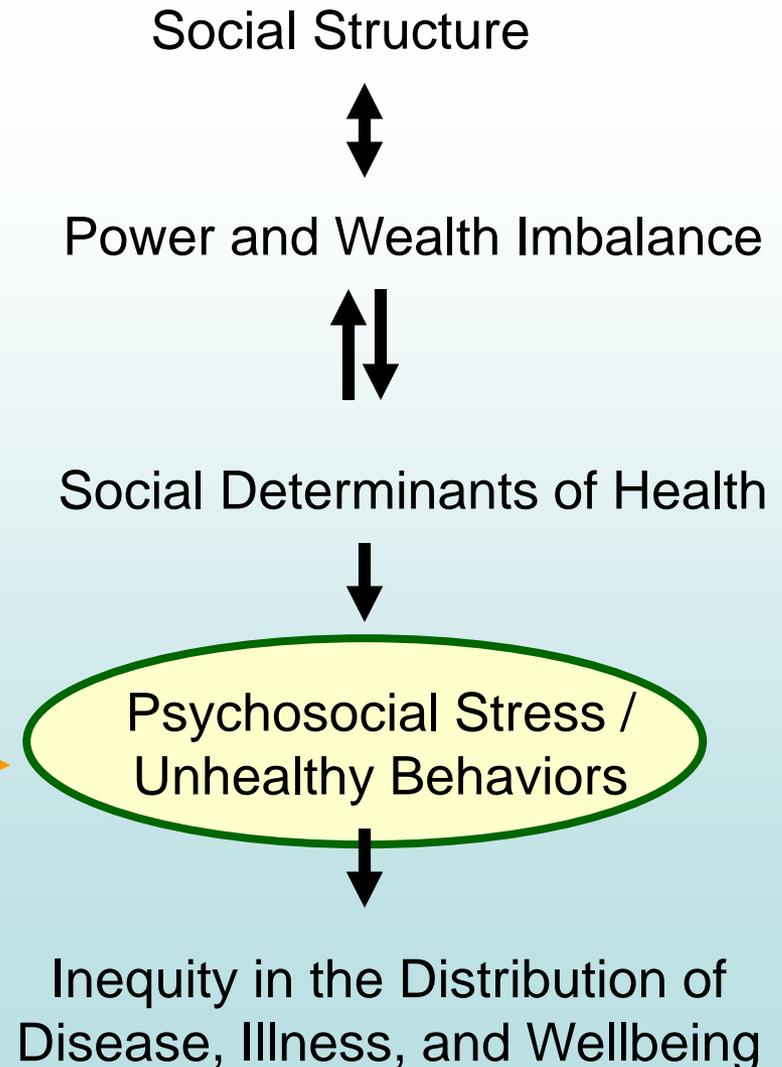


*Renée Branch Canady, CEO, MPHI  
August 6, 2015  
CECANF Meeting*

# Addressing Root Causes

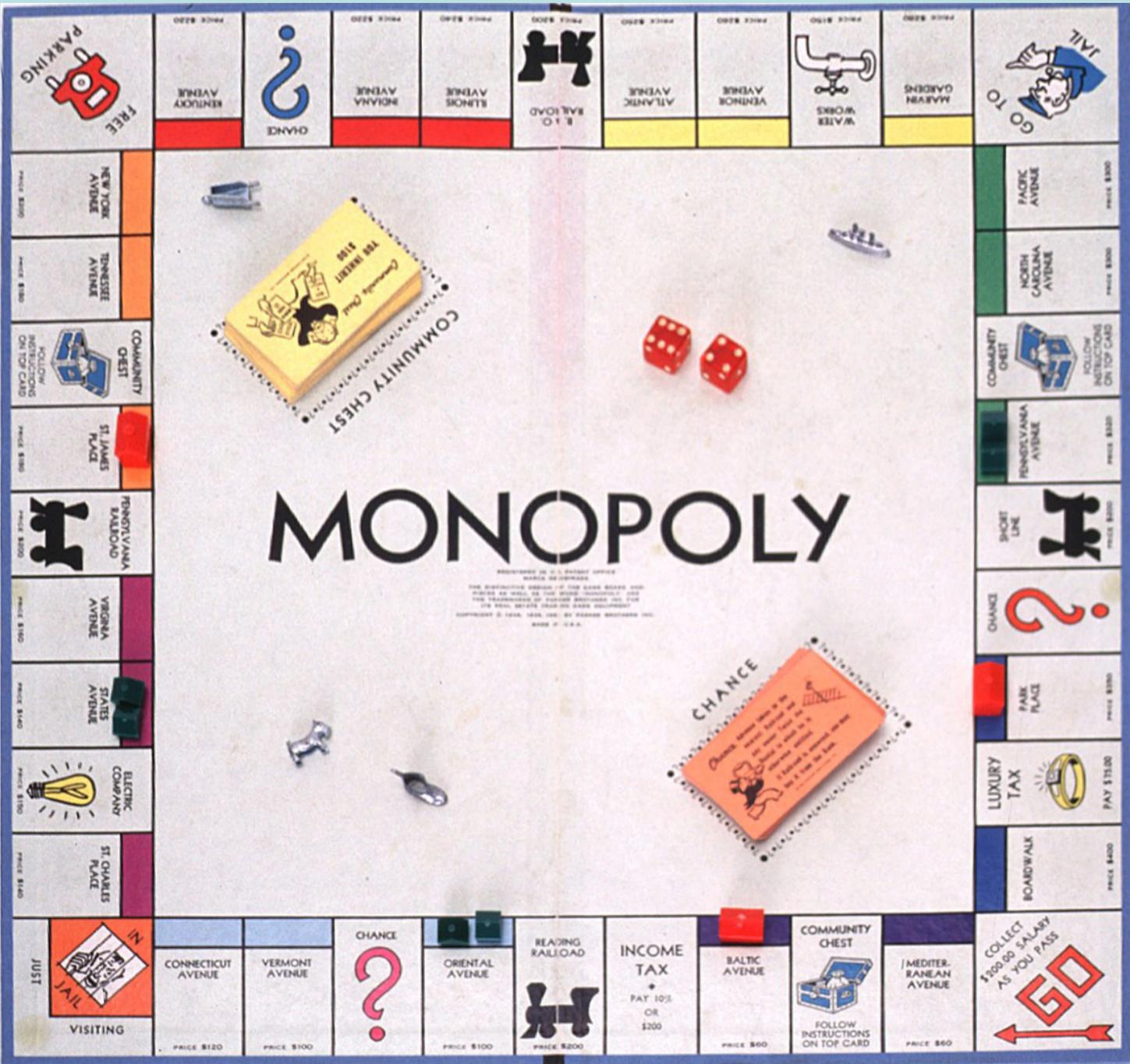
Despite available research, opinion leaders and policy makers give little attention to inequities and their root causes. Typically focus on remedial options...

Why?



“Public health problems pose special challenges. They are generally enormous in scale, stem from numerous and highly complex causes, play out in the public, impact a vast array of stakeholders, and require unusually long-term solutions.”

Koh & Jackson (2009) Fostering PH Leadership, Journal of PH, 31 (2), 199



FREE PARKING

PRICE \$200  
KENTUCKY AVENUE

PRICE \$200  
CHANCE

PRICE \$200  
INDIANA AVENUE

PRICE \$200  
ILLINOIS AVENUE

PRICE \$200  
E 1 O RAILROAD

PRICE \$200  
ATLANTIC AVENUE

PRICE \$200  
VENTNOR AVENUE

PRICE \$100  
WATER WORKS

PRICE \$200  
MAVER GARDENS

GO TO JAIL

PRICE \$200  
NEW YORK AVENUE

PRICE \$100  
TENNESSEE AVENUE

COMMUNITY CHEST  
FOLLOW INSTRUCTIONS ON TOP CARD

PRICE \$100  
ST. JAMES PLACE

PRICE \$200  
PENNSYLVANIA RAILROAD

PRICE \$100  
VIRGINIA AVENUE

PRICE \$100  
STATES AVENUE

PRICE \$100  
ELECTRIC COMPANY

PRICE \$100  
ST. CHARLES PLACE

JUST VISITING

PRICE \$120  
CONNECTICUT AVENUE

PRICE \$100  
VERMONT AVENUE

PRICE \$100  
CHANCE

PRICE \$100  
ORIENTAL AVENUE

PRICE \$200  
READING RAILROAD

INCOME TAX  
PAY 10% OR \$200

PRICE \$60  
BALTIC AVENUE

COMMUNITY CHEST  
FOLLOW INSTRUCTIONS ON TOP CARD

PRICE \$60  
MEDITERRANEAN AVENUE

COLLECT \$100.00 SALARY AS YOU PASS

PRICE \$800  
PACIFIC AVENUE

COMMUNITY CHEST  
FOLLOW INSTRUCTIONS ON TOP CARD

PRICE \$100  
PENNSYLVANIA AVENUE

PRICE \$200  
SHORT LINE

CHANCE

PRICE \$100  
PARK PLACE

PAY \$100  
LUXURY TAX

PRICE \$400  
BOARDWALK

# MONOPOLY

REGISTERED IN U.S. PATENT OFFICE  
TRADE MARK OF HASBROU INC.  
THE DISTRIBUTIVE DESIGN OF THIS GAME BOARD AND  
PIECES IS THAT OF THE BOARD COMPANY AND THE  
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THE RIGHT TO USE THIS BOARD COMPANY  
COPYRIGHT © 1988, 1989, 1990 BY HASBROU INC.  
MADE IN U.S.A.

COMMUNITY CHEST  
THE BREWERY  
Community Chest  
\$100

CHANCE  
Chance: Roll the dice and move your piece the number of spaces shown. If you land on a space with a Chance card, draw the card and follow the instructions on the card. If you land on a space with a Community Chest card, draw the card and follow the instructions on the card.

# A question of *HOW*?

## A Health Equity Vision of Leadership:

- Generally driven by a profound and fundamental sense of **mission**.
- A sense of purpose motivates them to leave the comfort of the sidelines and wade into **controversy**

# A question of *WHO*?

“Public health is what **we**, as **a society**, do ***collectively*** to assure the conditions for people to be healthy.”

IOM The Future of Public Health, 1988

# A Model of Shared Responsibility

**Individuals recognize ownership, empowerment & hope**

**Personal Responsibility**

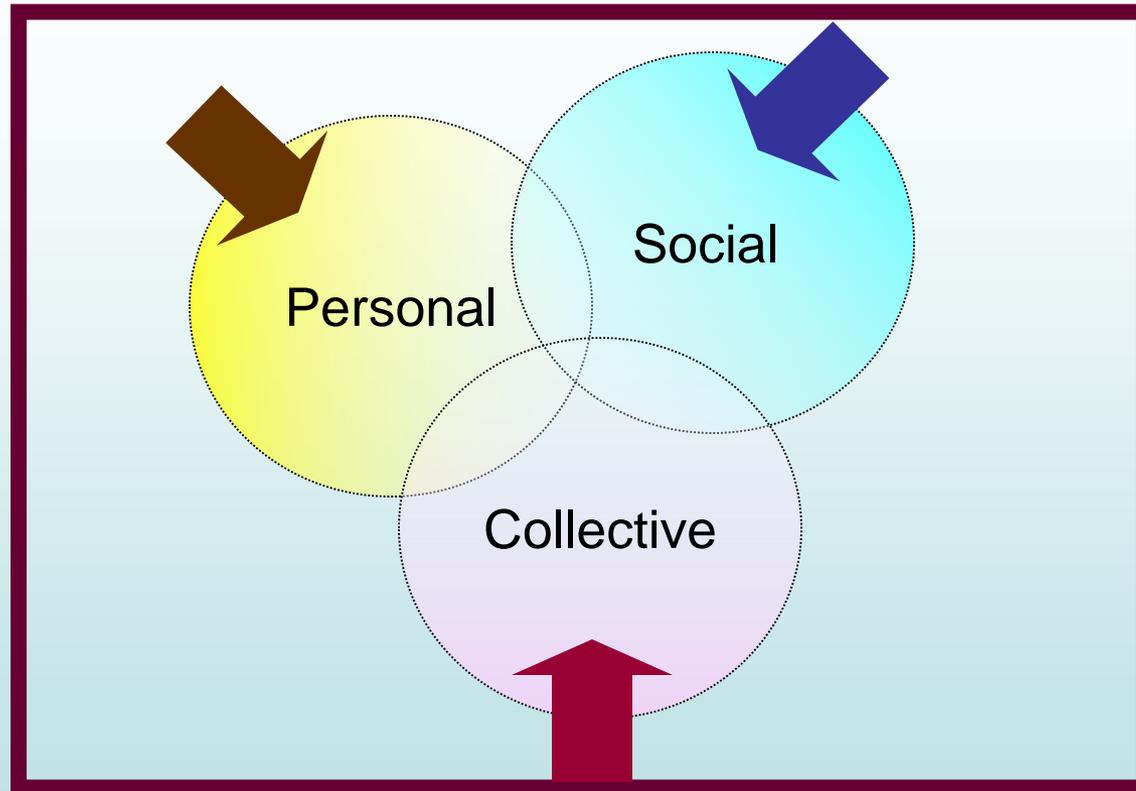
**Collective Responsibility**

**Social Responsibility**

**Public and Private Sector motivated to respond, challenges to status quo encouraged and welcomed.**

**Engagement of / Advocacy by community members who want to create change**

# “Three are Greater than One”



# Changing the Questions

Instead of only asking:

Why do people smoke?

Perhaps we should also ask:

What social conditions and economic policies predispose people to the stress that encourages smoking?

# Changing the Questions

Instead of only asking:

How can we create more green space, bike paths, and farmer's markets in vulnerable neighborhoods?

Perhaps we should also ask:

What policies and practices by government and commerce discourage access to transportation, recreational resources, and nutritious food in neighborhoods where health is poorest?

# Changing the Questions

Instead of only asking:

How do we connect isolated individuals to social supports?

Perhaps we should also ask:

What institutional policies and practices maintain rather than counteract people's isolation from social supports?

# Changing the Questions

Instead of only asking:

What prevention programs will reduce the incidence of child abuse and neglect in our community/country?

Perhaps we should also ask:

How could improved economic and living conditions reduce the likelihood of child being abused in their homes?

# Changing the Questions

Instead of only asking:

What prevention programs will reduce the incidence of child abuse and neglect in our community/country?

Perhaps we should also ask:

How do our institutional and interpersonal responses to child abuse and neglect perpetuate oppressive attitudes toward people of color and people living in poverty?

# A question of *WHAT?*

- Creating a standard
  - Transitions to Success (TTS)
- Changing the culture
  - Ingham Health Equity Social Justice Model

# Who's Accountable?

**“The poverty rate rises and falls with the state of the economy and is largely beyond our control. Solutions to this problem are elusive.”**

Source: The Opportunity Agenda  
([http://opportunityagenda.org/poverty\\_opportunity/mediaanalysis/dominant](http://opportunityagenda.org/poverty_opportunity/mediaanalysis/dominant))



*If you want to build a ship, don't drum up people to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea.*

Antoine de Saint Exupery

# Leveraging Advances in Aviation and Patient Safety, and Public-Private Partnerships to Eliminate Child Abuse and Neglect Fatalities

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Presentation to the Commission to Eliminate Child Abuse and Neglect Fatalities

August 2015



**MITRE**



# Overview

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- Overview of The MITRE Corporation and the Federally-Funded Research and Development Centers it operates
- Overview of recent advances in aviation safety and the MITRE-sponsored patient safety initiative
- Leveraging advances in aviation and patient safety and public-private partnerships to eliminate child abuse and neglect fatalities

The contents of this presentation reflect the views of the author and The MITRE Corporation alone and do not represent the views of any of our government sponsors.

# MITRE History & Background

MITRE is a **private, independent, not-for-profit** organization, chartered to work in the **public interest**.

**Founded in 1958** to provide engineering and technical services to the U.S. Air Force

**Supports a broad and diverse set** of civilian and defense **agencies**, as well as select international customers

Currently manages **Federally Funded Research and Development Centers\*** for

- **Department of Health and Human Services**
- Department of Defense
- Department of Homeland Security
- Federal Aviation Administration
- Department of Treasury and Department of Veterans Affairs
- Administrative Office of the U.S. Courts
- National Institute of Standards and Technology



1958

2013

\* And only FFRDCs

# What is an FFRDC?

Federally funded research and development centers (**FFRDCs**) were **created by the government** to address problems of **considerable complexity**, analyze technical questions with a **high degree of objectivity**, and provide **innovative and cost-effective solutions** to government problems.

FFRDCs have the following **characteristics**:

- Operate as **strategic partners** with their sponsoring government agencies
- Are organized as **independent entities** and must operate **free from organizational conflicts of interest**
- Bring together the expertise and outlook of government, industry, and academia to **solve complex technical problems**



# Unique FFRDC Relationship

- **Extra-ordinary Access**
  - Access to tools and industry for evaluation and research
  - Access to HHS data for research and direct work
- **The FFRDC Innovation Plan emphasizes the need to build out laboratory capabilities specific to HHS innovation needs**

From the Federal Acquisition Regulation (FAR) 35.017 FFRDCs:  
“(a) Policy

...

“(2) An FFRDC meets some special long-term research or development need...An FFRDC, in order to discharge its responsibilities to the sponsoring agency, has access, beyond that which is common to the normal contractual relationship, to Government and supplier data, including sensitive and proprietary data, ...”



# Combining Proprietary, Public, and Government Data to Improve Aviation Safety

---

**Edward Walsh**

**Associate Department Head**

**Aviation Safety Analysis**

**August 7, 2015**

The contents of this document reflect the views of the author and The MITRE Corporation and do not necessarily reflect the views of the Federal Aviation Administration (FAA) or the Department of Transportation (DOT). Neither the FAA nor the DOT makes any warranty or guarantee, expressed or implied, concerning the content or accuracy of these views.



# Aviation Example

**A collaborative Government-Industry initiative on data sharing & analysis to proactively discover safety concerns before accidents or incidents occur, leading to timely mitigation and prevention**



# Aviation Example

**A collaborative Government-Industry initiative on data sharing & analysis to proactively discover safety concerns before accidents or incidents occur, leading to timely mitigation and prevention**

- **Air Carriers (45)**
- **General Aviation (14)**
- **Industry (11)**
- **Government (5)**
- **Maintenance Repair & Overhaul (2)**
- **Academic (1)**
- **FFRDC (1)**

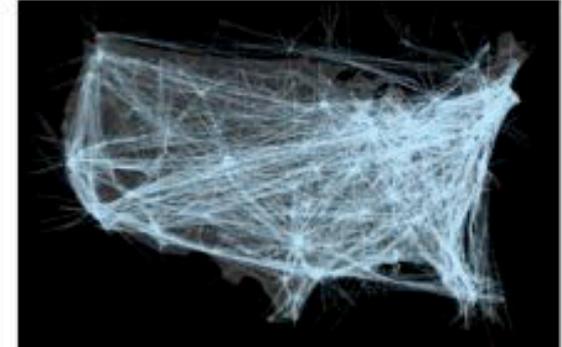
# Data Availability



**Airline Safety Reports**  
233,000 reports



**Digital Aircraft Data**  
15 Million Flights



**Radar Data**  
95 Million Flights



**ATC Safety Reports**  
77,500 reports



**Weather Data**



**Infrastructure Data**

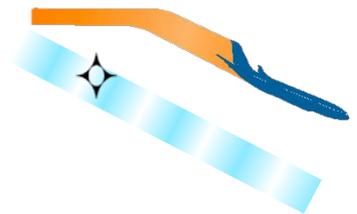
# What's Possible?



**Terrain Awareness Warning System Alerts**



**Missed Approach**



**Altitude Deviation  
Missed Crossing Restriction**

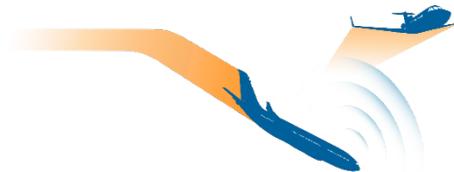


**Class B Excursion**



**Final Approach Overshoot**

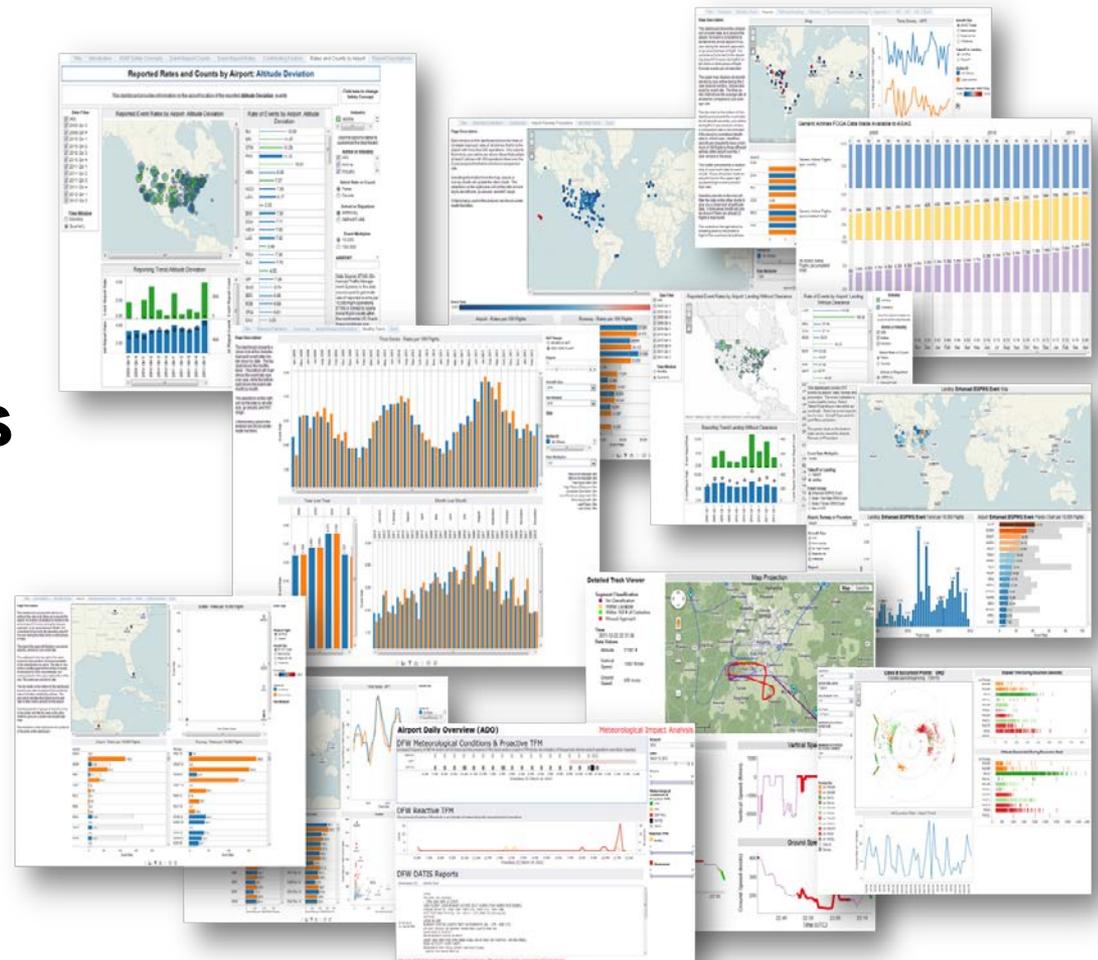
**High/Low Energy Approach  
Unstable Approach**



**Traffic Alert and Collision Avoidance System  
Resolution Advisories**

# What's Possible?

- **Safety enhancement assessment**
- **Benchmarking**
- **Directed studies**
- **Known risk monitoring**
- **Customization**



# Recent Results



## SAFO

Safety Alert for Operators

SAFO 14005

DATE: 11/25/14

Flight Standards Service  
Washington, DC

### airline\_safety/safo

*Attention. SAFO content should be especially  
of the highest possible degree of safety in the public  
domain may be as effective in addressing the safety*

121 Operators Flap Misconfiguration

**Purpose:** This SAFO serves to raise awareness of aircraft misconfigurations on takeoff with an emphasis on flap position.

# Lessons Learned



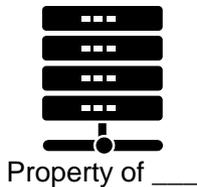
Collaborate with Industry



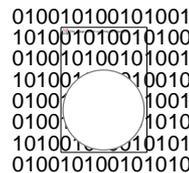
Give and Take



Operate Transparently



Respect Data Ownership



Safeguard Data



Serious Stewardship



Provide Insights

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# Patient Safety

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# MITRE Patient Safety Initiative

## Goals

Create a public-private partnership to discover new insights and interventions in health safety



**MITRE**

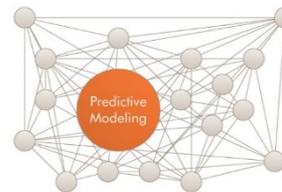


## Approach

Shared data: The whole is greater than the sum of the parts

Expertise: Partner clinicians with data scientists

Data science: Apply advanced analytics to foster new discoveries



## Expected Outcome

Reduce adverse events in health care

Save lives, avoid injuries, and save healthcare costs



# Leverage Diverse Data Sets

## Aviation



De-identified  
User Reports



De-identified  
Digital Flight Data



ATC Information



Weather

## Healthcare



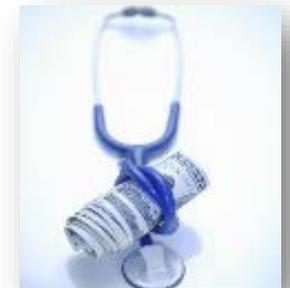
EHR Data



Safety Event  
Reports



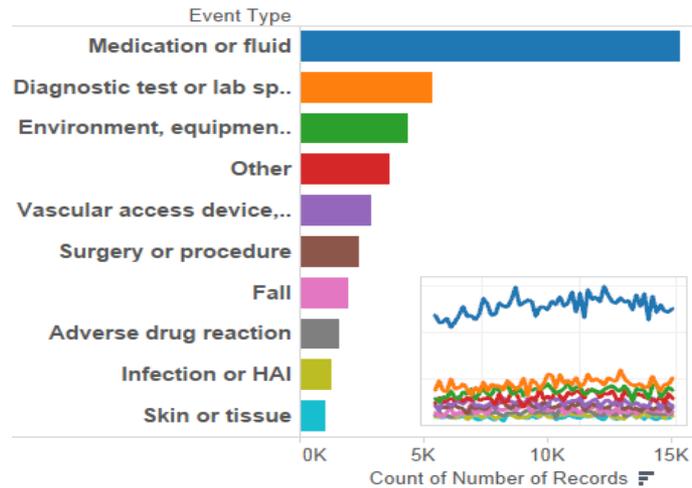
Physiologic  
Data



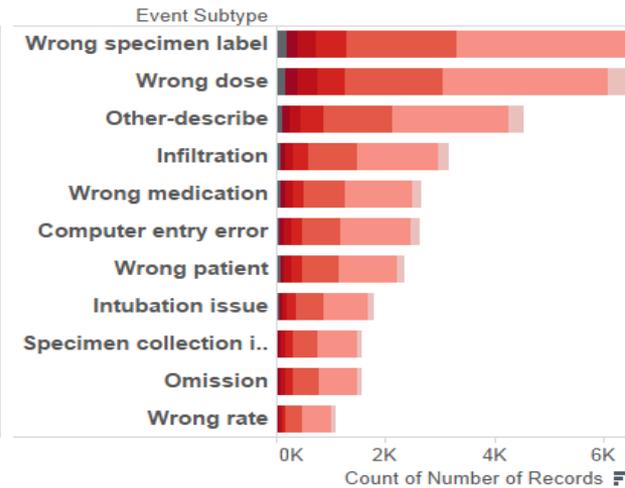
Administrative  
Data

# Insights to Interventions

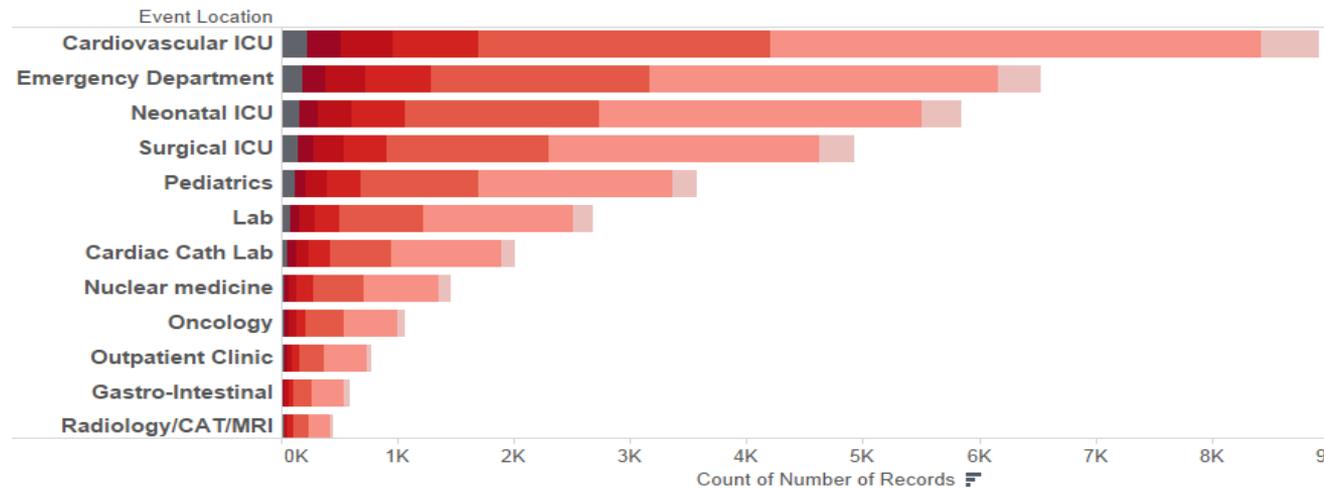
Safety Events by Type



Safety Events by Subtype



Events by Location



Event Date: (All)

CHEWS Score: (All)

Language: (All)

LOS before Event: (All)

LOS after Event: (All)

Patient Age: (All)

Choose Color

- Event Severity
- Event Preventability

Color Legend

- 0-Near Miss
- 1-None
- 2-Minor
- 3-Moderate
- 4-Major
- 5-Catastrophic
- Null

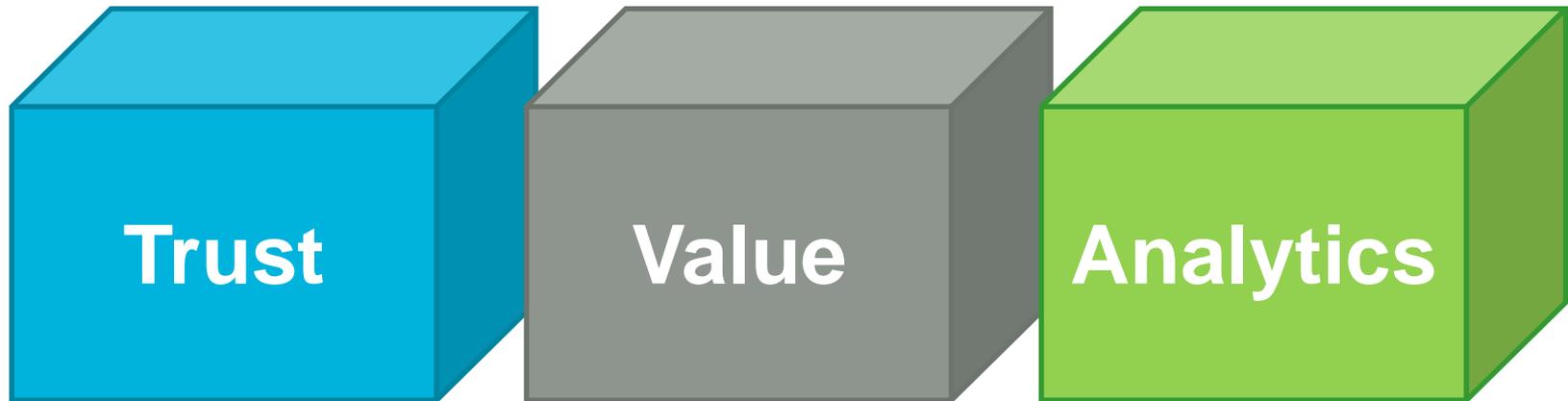
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# **From Aviation and Patient Safety to Preventing Abuse and Neglect Fatalities**

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# Building Blocks for Successful Public-Private or Public-Public Partnerships

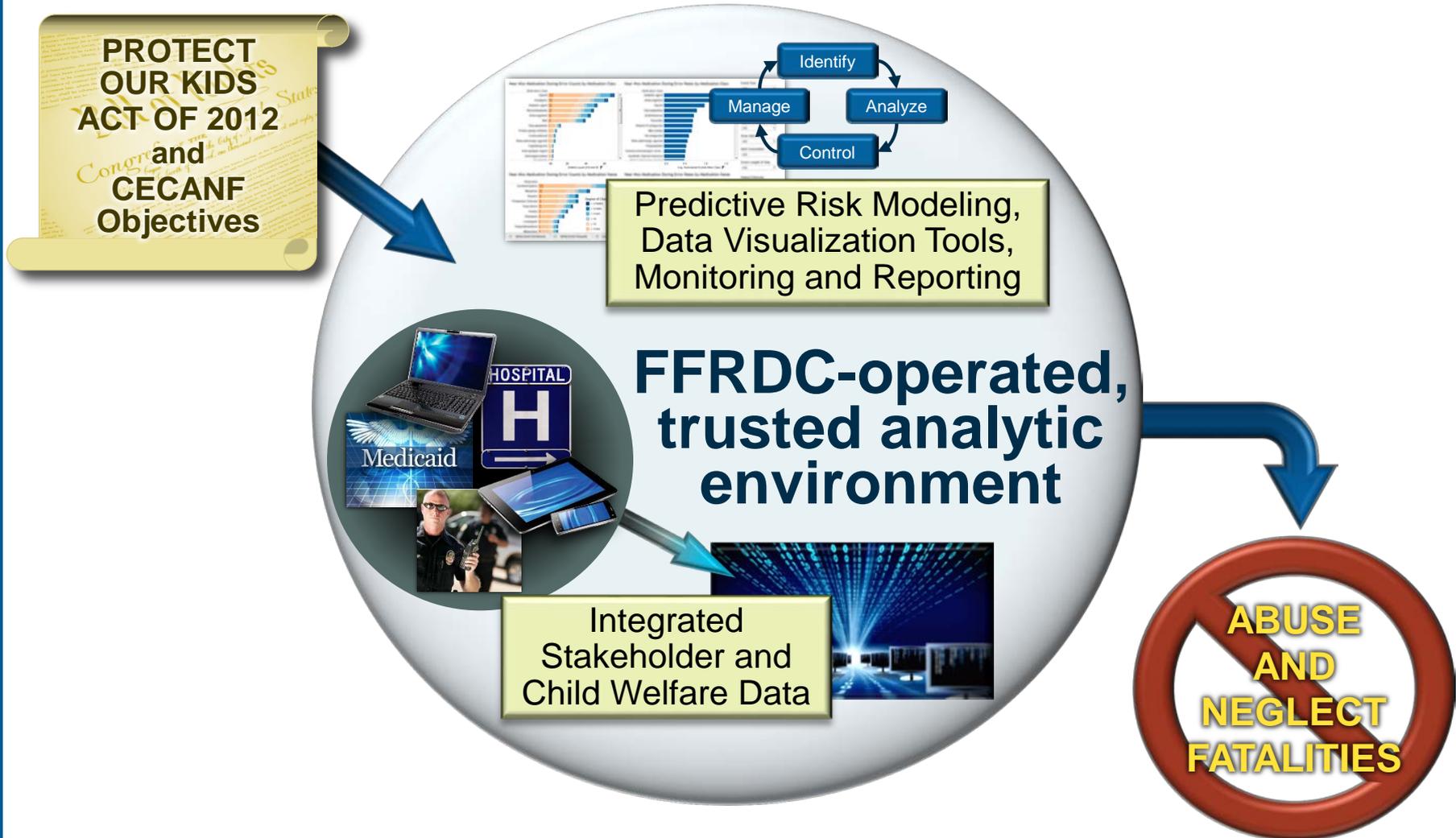
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# Child Welfare Faces Similar Barriers to Actionable Information

- Fatal victimization of children encompasses a **heterogeneous** and **complex** class of events
- A small number of state-based efforts show promise, but largely rely on limited agency or county cases; findings may not be **generalizable**
- **Poor data quality** and **inability to incorporate** a wider set of **data** are a major barrier for problem **identification** and **proactive intervention**
  - Much data are **not automated or easily accessed/integrated** (e.g., information from court records)
- CPS agencies
  - Often **lack empirically valid assessments** to effectively plan for children's safety
  - **High** child to caseworker **ratio** and **large amounts of related data**, much of which is **unstructured and/or not easily accessible**
  - Challenged to **identify** and **prioritize critical information** (signal vs. noise)
- **Lack of standard assessment tools** and **timely access to all known risk factors** hinders risk identification and intervention

# For Consideration: A National Public-Private Partnership to Eliminate Abuse and Neglect Fatalities



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# Q&A/Discussion

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# For more information, please contact:

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