



## COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

### MEETING MINUTES August 6-7, 2015

**Meeting Location:** ACS Children's Center Auditorium, 492 First Avenue at 28th Street, New York, NY 10016

**Commissioners Present:** Chairman David Sanders, Bud Cramer, Theresa Covington, Susan Dreyfus, the Hon. Patricia Martin, Michael Petit, Jennifer Rodriguez, Dr. David Rubin, Dr. Cassie Statuto Bevan, and Marilyn Bruguier Zimmerman

**Attending by Phone:** Amy Ayoub, Dr. Wade Horn

**Designated Federal Officer:** Amy Templeman, acting executive director, attended the meeting.

**Conduct of the Meeting:** In accordance with the provisions of Public Law 92-463, the Commission to Eliminate Child Abuse and Neglect Fatalities held a meeting that was open to the public on Thursday, August 6, 2015, from 8:00 a.m. to 5:30 p.m., and Friday, August 7, 2015, from 8:00 a.m. to 12:30 p.m., at the ACS Children's Center Auditorium. The purpose of the meeting was for Commission members to gather national and state-specific information regarding child abuse and neglect fatalities, including testimony on New York state and New York City's prevention efforts, racial disproportionality in child maltreatment fatalities, and public-private partnerships that collect and analyze data to promote safety in industries such as aviation and health care.

Commission members also discussed the work plans of the Commission subcommittees and the information that they have obtained to date.

Chairman Sanders indicated that audience members would not have the opportunity to ask questions during the proceedings and requested that audience members not engage in direct dialogue with the Commissioners. He suggested that any audience members wishing to comment could submit testimony or written feedback through the Commission's website.

#### THURSDAY, AUGUST 6, 2015

**New York State's Child Welfare System:** *Laura Velez, Deputy Commissioner, Division of Child Welfare Services, New York State Office of Children and Family Services (OCFS)*

Laura Velez, Deputy Commissioner, Division of Child Welfare Services, New York State Office of Children and Family Services (OCFS), welcomed everyone to New York and then provided statistics on the state's child welfare system. She offered the following information on the state-supervised, locally administered system:

- Reports of possible child maltreatment come to the state register, which then moves them to the appropriate county for investigation. The state provides oversight and technical assistance. Approximately 60 percent of calls are moved to counties for follow-up.
- Child protective services (CPS) has reviewed more than 1,600 child fatalities that came into the state register—about 14 percent of all child fatalities—in the last five years. The number of child fatalities with child welfare involvement has remained at about 270 annually, with New York City accounting for about 40 percent.
- Unsafe sleep is the leading cause of death in infants. These are often related to an infant sleeping in a bed with an adult. Often, the parent is under the influence of drugs or alcohol.

Deputy Commissioner Velez also discussed some of the state’s prevention measures:

- The state funds and supports several home visiting programs, such as Healthy Families New York, with 36 such programs across state.
- In March 2015, OCFS and the Department of Health held a summit on safe sleep for infants in order to develop a statewide response to these deaths. The state also participates in the federally sponsored Collaborative Improvement & Innovation Network to Reduce Infant Mortality (CollIN) initiative.

**New York City’s Child Welfare System: *Gladys Carrión, Commissioner, New York City Administration for Children’s Services (ACS)***

Gladys Carrión, Commissioner, New York City Administration for Children’s Services (ACS) provided an overview of child welfare work in New York City, focusing on the review of fatalities of children known to child welfare.

- ACS receives and investigates about 55,000 reports each year from the state register. Each report ends in being either “indicated” or “unfounded.” There is credible evidence for 40 percent of cases, which is higher than across the state.
- There are about 88 child fatalities each year in the city, 48 involving children known to ACS.

Since 1988, New York City has conducted accountability reviews of child deaths in families known to child welfare any time during the previous 10 years and reported to the state’s central register. The panel includes a variety of reviewers and makes recommendations for strengthening case practice, safety assessments, and supportive services. Recommendations have included raising awareness about unsafe sleep conditions, investigating all people in the household, better identification of children with special medical needs, and bolstering home visiting programs for families with young children. There are some common characteristics in the families of children whose deaths are investigated:

- A significant number of families in these cases experience domestic violence, substance abuse, homelessness, housing instability, and mental health issues.
- 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, and most of these victims are younger than 3 months old.

Commissioner Carrión described some of the ways that she has reorganized and revamped ACS, with a focus on promoting collaboration:

- The three separate child welfare units dealing with CPS, foster care, and adoption have been united under one umbrella to promote collaboration.
- ACS has hired 362 new positions and formed new units to review the most serious cases.
- ACS has reduced caseloads and numbers of children in foster care.
- New tools for workers and the integration of parent advocates have helped improve family engagement.
- There is greater integration of assessment tools in investigations.
- ACS has invested \$10 million to launch a workforce institute with the City University of New York to train workers.
- ACS employs more than 100 investigative consultants, who are retired law enforcement, to consult on specific cases.
- Mandatory cultural competence training for workers is designed to help address racial disproportionality in the child welfare population. ACS is also looking at programs in Nassau and Monroe Counties that use the practice of blind removals, in which decision-making participants in a potential removal are not provided with any demographic information that reveals the ethnicity or race of a family or children.

Commissioner Carrión also discussed prevention efforts throughout the city, including the following:

- ACS oversees 59 community-based organizations that offer nearly 12,000 preventive service slots serving 25,000 families a year.
- Services range from individual and family counseling to support groups, domestic violence services, and counseling to help families access benefits and the supports they need.
- One evidence-based model provides child-parent psychotherapy and seeks to support and strengthen the relationship by helping parents interact with their children in developmentally appropriate ways.
- To protect infants, ACS has Safe Care, which does weekly visits with families and shows parents how to bond with their children.
- As part the title IV-E foster care program waiver, ACS launched an attachment biobehavioral catch-up program in high-risk neighborhoods to provide 10 weeks of in-home coaching that helps both the infant and the parent.

Commissioner Carrión ended by describing the mayor's creation of the New York City Children's Cabinet, which brings together many agencies to focus on the well-being of the city's children.

### ***Commissioner Discussion***

The Commissioners asked questions of Deputy Commissioner Velez and Commissioner Carrión regarding barriers to collaboration among agencies and definitions of maltreatment. The following points were made in response:

- The formation of the Children’s Cabinet in New York City has helped promote collaboration, co-location, and cross-training among agencies. The federal government should model this behavior.
- New York City’s ACS recently hired a Medicaid expert to help the agency redesign the system to take advantage of Medicaid benefits for eligible children.
- ACS created an Office of Parent Engagement and Youth Advocacy to integrate the parent voice into the work and improve parent engagement.
- There should be a federal definition of a child or family “known to the system.”

### **A Dual-Generation Approach to Preventing Maltreatment Fatalities: *Panel Presentation***

Two presenters discussed preventing maltreatment fatalities by identifying and intervening with high-risk parents in a primary care setting.

#### ***Dr. Rahil Briggs, Albert Einstein College of Medicine and Healthy Steps at Montefiore***

Dr. Briggs, a pediatrician and director of Healthy Steps at Montefiore in the Bronx, New York City, described how the Healthy Steps program is able to identify and help at-risk mothers when they bring their newborns to the pediatrician. In the Bronx, where the vast majority of parents use Medicaid and live below the poverty line, parents are still active in seeking pediatric care. Dr. Briggs described some of the characteristics of Healthy Steps:

- Pediatric services are universally accessed and are viewed positively.
- This program focuses on preventing adverse childhood experiences (ACEs) before they occur with infants and children.
- There is a special focus on the mother’s mental health, including universal depression and mental health screening for parents and ACEs screening, as well as determining whether the mother experienced abuse or neglect as a child. Research showed that if a mother had experienced maltreatment as a child and her child did not receive Healthy Steps intervention, the child was at high risk for maltreatment.
- In order to determine which children should receive Healthy Steps interventions from among the 100,000 children who access services at Montefiore, Healthy Steps services are offered to families whose mothers had high prenatal ACEs scores.

Dr. Briggs ended with several recommendations:

- Payment reform must go beyond screening and include work with both mothers and babies, prevention, etc.
- Medical necessity should be redefined to reflect, for example, the risk of being born to a mother with depression.
- A capitated payment rate should be available to reimburse for practices that have behavioral health staffing.

#### ***Dr. Angela Diaz, Icahn School of Medicine at Mount Sinai***

Dr. Angela Diaz, Icahn School of Medicine at Mount Sinai, described her work as a pediatrician working with at-risk teenage girls. She offered the following observations:

- Girls who experience child abuse and neglect are at greater risk of becoming teenage mothers than their nonabused peers.
- Adolescent mothers are more likely to experience compounding life stressors, including depression, stress, domestic violence, and substance abuse. Also, adolescent mothers are more likely to be single parents, to receive late or no prenatal services, and to experience postpartum depression and other stressors compared to adult mothers.
- All of these factors put the adolescent parent at greater risk for fatal maltreatment of her child. The most important risk factor for infant mortality is multiple children born to a mom younger than 17. Children of these mothers are 11 times more likely to end up as child fatalities.

Dr. Diaz noted that adolescents will seek OB/GYN care, so the OB/GYN clinic or office is a place to offer services and support. In her practice at Mt. Sinai, Dr. Diaz found that, of young people she sees regularly for routine care, 23 percent report sexual abuse, mostly incest, when asked. Of those, 81 percent accept referrals to counseling. One-third have had multiple abusers, and most abuse starts before puberty.

Dr. Diaz offered the following policy recommendations:

- Screen adolescents, including pregnant and parenting teens, for a history of child maltreatment, depression, and substance use; connect them to interventions, and ensure access to services.
- Integrate primary care with services for sexual and reproductive health, mental health, and substance abuse prevention/treatment.
- Ensure that all services for adolescents are trauma informed.
- Ensure that adolescents have access to health education, including comprehensive sexuality education in schools and during health care, and 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 prevention services at every stage.

### ***Commissioner Discussion***

Commissioners and panelists made the following points in discussion:

- Dr. Briggs clarified that Healthy Steps is able to screen parents initially as part of their infant's care, and the parent's screening results go into the infant's chart.
- There should be a focus on providing early services to youth in foster care, because this population typically has a high number of ACEs and they are easily located. In addition, they need to learn healthy parenting.

### ***New York City's Children's Cabinet: Richard Buery, New York City Deputy Mayor for Strategic Policy Initiatives***

Deputy Mayor Buery described the creation and goals of the New York City Children's Cabinet, which was formed as an initiative of the mayor in April 2014 in response to the death of 4-year-old Myls Dobson. The cabinet includes 24 city agencies and is chaired by Buery. The city worked with Casey Family Programs to look at models of children's cabinets across country and determine how to set up

the New York City cabinet.

There are three focus areas:

- Align policy and practice to reduce barriers to services and provide a consistent message to families.
- Integrate data and analytical tools across agencies, and develop new data-sharing agreements.
- Develop programs, such as the Talk to Your Baby campaign, which encourages parents to talk, read, and sing to infants to help infant brain development.

Deputy Mayor Buery concluded by saying that the Children’s Cabinet has had a productive first year and is looking forward to more collaborative work in the future.

### ***Commissioner Discussion***

The Commissioners asked about barriers to sharing data, and Buery responded by saying that HIPAA (Health Insurance Portability and Accountability Act) and FERPA (Family Educational Rights and Privacy Act), as well as state and city laws, make it difficult to share data across agencies.

### ***Building for Success: Universal Evidence-Based Maternal Home Visiting: Senator Daniel Squadron, New York State Senate, 26th District***

Senator Squadron presented on the evidence-based home visiting programs in New York state, with a special focus on the Nurse-Family Partnership (NFP) program. There are currently three evidence-based home visiting programs in New York: NFP, Healthy Families New York, and Parents as Teachers, each of which supports families at a different stage and costs a different amount (\$7,000, \$3,500, and \$2,600 per family annually, respectively). Senator Squadron stated that there is a need for universal home visiting, making the following points:

- Universal home visiting means that every expectant high-risk mother would be offered a program at her first prenatal visit.
- These programs would result in significant taxpayer savings by reducing future costs associated with child maltreatment, poor health, and academic failure. There are also reductions in involvement in criminal activity for children and increases in parent self-sufficiency and father presence.
- For New York to move to universal home visiting, the state would need to increase funding from \$43 million to \$256 million. Medicaid, other federal funding, and state funding are some ways to pay for this.
- The social impact bond model, in which private investors provide program costs and are repaid only if the program results in savings, provides a promising way to fund home visiting programs.

### ***Commissioner Discussion***

The following points were made during the discussion:

- The social impact bond model could be applied to an incremental approach.
- New York was denied direct eligibility for Medicaid to pay for home visiting programs.

## **New York City's Safe Sleep Initiative: *Panel Presentation***

Three presenters from different New York City agencies (the Department of Health and Mental Hygiene, ACS, and the Department of Homeless Services) presented on the city's Safe Sleep initiative, which they operate jointly. This committee of three departments was formed in 2004-05 and decided to focus on sleep-related deaths.

### ***Dr. Oxiris Barbot, First Deputy Commissioner, New York City Department of Health and Mental Hygiene***

Dr. Barbot, who heads the city's Department of Health and Mental Hygiene, opened the session by presenting statistics on infant mortality and racial disparity in mortality in New York City:

- Infant mortality has been trending downward for 20 years, and the rate is currently at a historic low of 4.3 deaths per 1,000 live births.
- There are still significant disparities in mortality between black and white babies, and these disparities are getting worse. Black babies are 2.8 times more likely to die than white babies, and most neonatal and postnatal deaths are related to prematurity and low birthweight.
- In the postneonatal period, sleep-related injuries and suffocation are among the leading causes of death.
- Babies born to African American women in New York City are three times more likely than Latino babies and five times more likely than white babies to die of sleep-related death.
- Among babies who died of a sleep-related death, 40 percent were sleeping on their stomach, 60 percent had excess bedding, and 56 percent were in bed with another child or an adult.
- The committee joined the National Cribs for Kids program in 2007. Since then, 42,000 families have received education on safe sleep and more than 6,000 cribs have been distributed.

The three agencies have a standardized message to ensure that all are saying the same thing about sleeping. Shifting the focus to a public health perspective would mean that parents would receive education on the importance of safe sleep.

### ***Dr. Jacqueline McKnight, Executive Deputy Commissioner, Child Welfare Programs, New York City ACS***

Dr. McKnight of ACS presented statistics on sleep-related fatalities in New York City among families known to ACS and discussed some of the prevention measures that ACS is putting in place. Among fatalities due to unsafe sleep from 2010 to 2014, approximately half occurred in families known to ACS. In 2014, that percentage dropped to 33 percent, possibly due to strong prevention efforts.

Prevention efforts include the following:

- The hiring of community coordinators to work in neighborhoods with a high number of sleep-related infant death
- Production of a 30-second public service announcement about safe sleep
- Targeted outreach to new parents
- Coordinated efforts to collect and analyze data

***Lorraine Stephens, First Deputy Commissioner, New York City Department of Homeless Services***

Lorraine Stephens, with the Department of Homeless Services, was the panel's final presenter. She provided statistics on the 11,000 homeless families with children in New York City. Forty percent of these families include a child who is age 5 or younger, and 24 percent have an open case with ACS. Stephens discussed ways that the city has strengthened safe sleep in shelters, including the following:

- Instituted a joint case record review initiative with ACS and worked with ACS to come up with an assessment instrument
- Established additional ACS units to help make assessments, including a special focus on identifying children with high-risk medical needs
- Increased family visits, so that families in shelters with children under age 5 receive a weekly visit with ACS that includes safe sleep instruction
- Linked families to early child care and preventive services
- Hired a special team of social workers to visit each of the 2,500 families in shelters
- Enhanced services at intake, including providing a video for families on safe sleep practices
- Trained shelter staff on child abuse and neglect and on safe sleep

***Commissioner Discussion***

The following points were made during questions and answers after the panel presentation:

- Reinforcement about the safe sleep message is essential with many families, and social workers often need to go back and check on families to ensure that they are placing babies alone in a crib on their backs.
- ACS has never removed a child from parents because of unsafe sleeping practices.
- In order to address the high percentage of sleep-related deaths in minority populations, New York City is targeting neighborhoods where higher percentages of babies die, using credible community messengers to reinforce safe sleeping practices, exposing multigenerational caregivers to the message, and tapping into faith-based communities.
- Although substance-using mothers have not been targeted by this group for interventions, mothers with alcohol or drug problems are referred to services, and the Safe Sleep Campaign committee has relationships with service providers.

***New York City's Instant Response Teams and the Role of Clinical Consultation in Child Welfare Practice: Panel Presentation***

This panel presentation described the city's Instant Response Teams (IRTs), a partnership between ACS and the New York City Police Department (NYPD), as well as a clinical consultation program for specialists in other services.

***Susan Morley, Senior Advisor for Investigations, New York City Administration for Children's Services***

Susan Morley, with ACS, related the history of the IRTs, which began in 1998 in response to a child

death and are now used with investigations into cases involving the most severe maltreatment. She shared the following information on the IRTs:

- Currently, about 4 percent to 6 percent of ACS cases call for an IRT, including all cases involving fatalities, severe physical abuse, sexual offenses, and all cases that would benefit from a multidisciplinary approach.
- A goal of the IRTs is to minimize trauma to children by ensuring that they are not interviewed multiple times by multiple people.
- Either agency—ACS or the NYPD—can initiate an IRT.
- Since 2006, ACS has hired investigative consultants, former detectives who work with CPS staff on difficult cases.
- A more recent enhancement to IRTs has been a database that shares information among agencies, collects data, and produces reports. Investigators now have direct access to criminal and domestic violence databases.
- They also work to identify youth who are victims of trafficking.
- The IRTs do a lot of work on recantation and how and why that happens.

***Deputy Chief Michael Osgood, Commander of the New York City Police Department, Special Victims Division***

Deputy Chief Osgood described his responsibilities and experience with child abuse fatalities, including managing the Special Victims Division of the NYPD. He emphasized two main points:

- The importance of an immediate and rigorous investigation in cases of child abuse fatalities and the immediate arrest of perpetrators when there is evidence
- The complexity of these cases and the need for experienced and trained investigators across fields

Deputy Chief Osgood made four recommendations to the Commission:

- Dedicate funding to enhance the current body of research on child physical abuse and medical science.
- Fund child abuse investigation training for police officers.
- Fund training for medical doctors, not just pediatricians but also emergency room physicians, who are often the first to encounter the injured child.
- Support and embrace child advocacy centers, which play a key role in the child abuse investigative process.

***Andrea Goetz, Assistant Commissioner, Clinical Practice and Support, New York City ACS***

Assistant Commissioner Goetz described her experience with launching a clinical consultation program in 2002 to increase the capacity and improve decision-making of ACS frontline staff. The program offers consultation with clinical experts in medical health, mental health, domestic violence, and substance abuse. Experts are co-located with ACS staff. In 2014, almost 42,000 consultations were provided across the four disciplines.

Goetz described the four types of consultations:

- CPS workers administer universal screenings for domestic violence. A CPS worker may then request a consultation with a domestic violence expert, who is able to point out the patterns of abuse and make recommendations for safety planning and service referrals, using gender-neutral language that highlights coercive and controlling behaviors. A batterer responsibility program is offered to the abusive partner, and child-parent psychotherapy is offered to the survivors with young children in order to address past and current trauma and support them in creating and maintaining a healthy relationship.
- Medical consultations are made with nurse practitioners who are supervised by a physician who is an expert in child abuse. The nurse consultants can be especially helpful in cases where children have special medical needs, because these special needs can put extra stress on families, and that stress can contribute to abuse. The addition of the medical consultants can play an important role in preventing serious injury or fatality.
- About 25 percent of cases involve mental health issues in parents. Clinical consultations in mental health may look at trauma and the childhood experiences of parents, especially looking for whether or not the parents were abused as children. Mental health consultations are child centered, stress based, and trauma informed. Consultants are licensed social workers with experience in child welfare.
- Substance abuse consultations account for about 20 percent of all consultations, although this problem is probably underreported. Substance abuse screening and services are co-located in the ACS offices and provided by credentialed alcoholism and substance abuse counselors. The counselors meet directly with families and can do the screening and provide services on site.

Goetz noted that consultants can assist CPS workers in identifying issues of concern that impact social-emotional health, positive parenting, and the well-being of the family. Once CPS workers understand the family's background and how they function, they are in a better position to assess the family's strengths and needs. In addition, clinical consultation teams participate in child safety and family conferences, offer crisis debriefings following a fatality or a particularly intense case, and offer training in their areas of expertise.

### ***Commissioner Discussion***

The following points were made in questions and answers between Commissioners and the panel:

- New York City has been addressing the problem of trafficking of children by training ACS workers in recognizing trafficked children. ACS has a foster care program for youth who want to leave trafficking and a Safe Horizons Center funded by Safe Harbor funding. ACS is currently testing screening tools for trafficking.
- The agencies struggle with the barriers to sharing data; for instance, they are not permitted to share what they learn in family court regarding all of the adults in a household.
- Co-locating services such as substance use services for parents in the same building as ACS means that parents often can connect with services more quickly.
- It is difficult to know how many child fatalities involve a parent under the influence of drugs or alcohol because parents are rarely tested for substances in their system at the time of a child's death.

**Child Deaths: A Perspective from the Field: *Dr. John Mattingly, Retired Child Welfare Commissioner, New York City ACS***

Dr. John Mattingly, former commissioner of ACS, discussed his experiences in leading the New York City child welfare system and the issues that arise in these large systems. He noted that child welfare, unlike juvenile detention, does not have standard criteria for making decisions about cases. Although there is no easy answer to preventing child fatalities from abuse, there are ways to make the system work more effectively. Dr. Mattingly talked about two cases to illustrate the complexity of the decision-making process in child welfare:

- The first case involved a false accusation of parents in an immigrant family.
- The second case involved a set of child welfare scenarios that the Annie E. Casey Foundation has been developing in order to train child welfare workers in decision-making.

Dr. Mattingly also critiqued the hiring process for child welfare workers, which is long and not sufficiently related to the job skills needed. He made the following specific recommendations:

1. Overhaul the process of hiring and training workers.
2. Design a child welfare decision-making process that includes families, relatives, and parent advocates, as well as an experienced facilitator.
3. Ensure that leaders know what is actually going on in their systems and on the front lines. In New York City, they started a process called ChildStat, which was a weekly review of two cases broadcast across all offices. Workers learned through hearing about and discussing these cases, and the information was consistent across offices.

**The Problem of Disproportionality, Associated Factors, and Promising Practices: *Panel Presentation***

Four panelists presented on the topic of disproportionality in child abuse fatalities and in child welfare involvement.

***Dr. Rita Cameron Wedding, Department of Women's Studies and Professor of Women's Studies and Ethnic Studies, California State University, Sacramento***

Dr. Rita Cameron Wedding of the University of California at Sacramento talked about implicit bias and its relevance for interactions with families before a child maltreatment death occurs. She noted that implicit bias refers to the fact that everyone has biases, and biases affect decision-making.

Some of the common biases surrounding families involved with child welfare include the following:

- The belief that black families are inherently not good families or that black parents do not have good parenting skills
- Biases around neighborhoods and assumptions about the people who live there
- Biases that social workers may have against parents with particular attitudes
- Biases that show up in language, for instance, when a white mother is described as “upset” but a black mother is described as “angry,” or when a white mother is described as having “no drug involvement” but a black mother is described as someone who “denies drug involvement”

Biases affect child welfare decision-making such that identical risk factors for white and black families often result in white families receiving in-home services and black children being removed and placed in foster care. The differential treatment of black families also makes it less likely that black families will seek help, so it pushes them away from the safety net. Dr. Cameron Wedding also noted that cases of abusive head trauma may be less likely to be identified in white families.

Dr. Cameron Wedding offered the following recommendations to the Commission:

1. Conduct research on how implicit bias in individuals and agencies impacts service delivery.
2. Explore whether disparities in child welfare outcomes—such as black children being removed more often from the home—is actually related to implicit bias.
3. Discuss whether a mandatory standardized risk assessment should be used in all deliberations about indicated child abuse and neglect in order to reduce implicit bias.

Dr. Cameron Wedding also suggested that new child welfare methodology should include the implicit bias technology to improve the accuracy of data production.

***Dr. Paul Elam, President, Public Policy Associates***

Dr. Paul Elam, of the Public Policy Associates of Michigan, was the second panelist, and he presented on the topic of reducing disproportionate minority contact in Michigan's child welfare system. Dr. Elam traced the steps that led to Michigan's reduction in disproportionate minority contact:

- Beginning in 2007, child welfare research was conducted in the urban counties of Saginaw and Wayne in Michigan.
- Researchers found disproportionate outcomes and disparate treatment, often involving minority workers, which led to the conclusion that racism had been institutionalized in the child welfare systems.
- In response, the Michigan Race Equity Coalition was established in 2009, chaired by a state supreme court justice. Its charge was to identify the key decision points that contribute to disproportionality and to develop plans to address it, including goals for measurable change.
- The coalition developed state and local leadership teams and established a demonstration site in Saginaw.
- Using surveys, focus groups, and interviews, the coalition identified five decision points where disproportionality could occur.
- The coalition found that minorities were more likely than white children to be investigated, be removed, age out, and die in the system.
- To address these findings, the coalition disseminated their report and also provided cultural competence training for both child welfare workers and law enforcement personnel.

Dr. Elam noted that they are already seeing promising approaches from this work, including data-driven decision-making, collaboration among system leaders, increased culturally responsive practice, more youth and family engagement, and a focus on addressing the underlying causes of abuse and neglect.

***Chet Hewitt, President and CEO, Sierra Health Foundation***

Chet Hewitt, of the Sierra Health Foundation, made his presentation via telephone. His organization

focuses on health equity and reducing disparity, specifically, reducing the high proportion of African American child deaths in Sacramento County.

Hewitt described the sequence of steps that led to the recognition of the disparity in child deaths:

- In 2011, the county death review team released a report based on 20 years of data that showed that African American children were dying of maltreatment at much higher rates than white children. The report 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. There was evidence that interventions that worked for other children and families in Sacramento County were having a less robust effect with African American children.
- To address the disproportionality, a blue ribbon commission was organized and charged with making recommendations to reduce African American child death rates by 10 percent to 20 percent by the year 2020. The commission is currently working on an implementation plan for its recommendations.
- The recommendations target six Sacramento neighborhoods that account for the great majority of African American child deaths. These neighborhoods share a number of risk factors, including higher rates of childhood trauma, poverty, and poor school performance and attendance.
- Implementation will involve collaboration across family service systems, as well as community and family and youth engagement and development.
- Community engagement is also a large component of the implementation. Recently, 300 residents joined the coalition's "Get on the Bus" campaign to ensure that county supervisors approved the budget to finance the implementation.

Hewitt noted that three factors were critically important:

- Twenty years' worth of data to make a case
- Community mobilization
- Multisystem collaboration

***Dr. Renee Canady, CEO, Michigan Public Health Institute***

Dr. Renee Canady, from the Michigan Public Health Institute, was the final panelist to speak on disproportionality. She began with two analogies:

- The first showed two individuals climbing ladders, each with a different number of rungs.
- The second analogy involved a Monopoly game in which players started the game at different times.

In both cases, there were advantages for an individual or individuals that put them ahead of the others. Dr. Canady argued for the involvement of the community to collectively make changes. Collective responsibility would involve both public and private sectors coming together to change the status quo. Dr. Canady suggested that questions need to be reframed in the following ways:

- Instead of, "How do we connect isolated individuals to social support?" ask, "What policies and practices maintain rather than counteract their isolation from social support?"

- In addition to asking, “What prevention programs will reduce the incidence of child abuse and neglect in our community or in our country?” 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?” and “How would we improve economic and living conditions to reduce the likelihood of children being abused in their home?”

Dr. Canady discussed the need to create standards in child welfare that are replicable around the country and build a sense of accountability. This is akin to a public health approach. She also mentioned facilitated dialogue as a way of engaging people in change.

Dr. Canady concluded by offering four recommendations to the Commission:

1. Try to figure out what is working and replicate that.
2. Change the narrative. For instance, instead of continuing to talk about vulnerable mothers, talk about mothers who are living in inadequate communities or communities that lack acceptable resources.
3. View poverty as a condition and not as a character flaw.
4. Create standards and shared replicable norms about how families are engaged.

### ***Commissioner Discussion***

The following points emerged from the subsequent follow-up discussion by the Commissioners and the four panelists:

- Because there is bias in the data that are collected, sharing those data across systems also can perpetuate the bias.
- Bias is not a cause but it is a contributor to the disproportionate number of minority children in child welfare. Implicit bias needs to be considered along with other factors. Are there families with significant pathologies? Yes, there are. We can’t just choose sides. It’s more than one thing.
- The field continues to respond to child maltreatment deaths at the personal and behavioral levels and does not yet respond at the collective, societal level.
- The faith community has a role to play in reaching out to the community and helping to take care of people.
- Consider using some portion of categorical funding for innovation.
- Consider decision-making tools to reduce bias. For instance, workers could be provided with a bench card that would remind them about asking specific questions of every family. However, monitoring for bias would still need to occur.

Chet Hewitt offered four recommendations to the Commission that he had not had the opportunity to include in his presentation:

1. Focus more upstream on parent and community engagement, prevention, and family strengthening, which is the most underfunded part of the child welfare system.
2. Focus more on family development.
3. Strengthen data collection, and have an independent review of fatalities.

4. Make broad use of validated screening tools to help address bias. Workers need to treat risk and remove for safety.

### **Commissioner Deliberations: Military Subcommittee**

The Commission's Military Subcommittee described working with the military's Family Advocacy Program (FAP), which is responsible for researching and reporting child abuse fatalities in military families. All service branches require fatality reviews of domestic violence cases in which a murder occurred, as well as cases of child death in which child abuse or neglect is suspected. For a number of years, it was about 80 deaths annually; depending on the branch of the service, these were reviewed at the installation or national level.

The Military Subcommittee drew up a list of questions for staff who work in the FAP, and the military sent out the questions to FAP offices. Respondents noted the following challenges in addressing child abuse fatalities:

- Frequent command changes cause frequent policy changes.
- People are reluctant to report child abuse or neglect because it can end someone's career.
- There are problems with sharing information with the civilian CPS office. Although the FAP office is required to share information with local CPS, the local CPS often does not reciprocate. Only three states require local CPS to share with military. Therefore, the military often does not know if they have families involved with local child welfare services, and they are not able to offer the military's services to the family.

The Subcommittee members noted that they had not yet had time to put their report into writing. Also, they noted that the military FAP staff were not able to provide written recommendations.

### **Commissioner Deliberations: Testimony Themes and Recommendations**

Staff described reviewing 70 pages of testimony and pulling out the recommendations from invited speakers through May 2015, which were then coded and categorized. Forty-three themes fell into two main categories. The top themes under each category are listed below:

- Mechanism themes
  - Funding
  - Federal issues/recommendations/legislation
- Content themes
  - Information sharing
  - Coordinated approach/reducing silos
  - Prevention
  - Record keeping/data systems

Staff referred to this document: *CECANF Recommendations: Qualitative Review Overview* ([https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF-Qualitative-Review-Overview\\_recommendations\\_8.5.15.pdf](https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF-Qualitative-Review-Overview_recommendations_8.5.15.pdf))

Commission discussion revolved around the following points:

- The final report will probably need a chapter on American Indian children.

- The staff's summary of recommendations is not the same as the recommendations themselves.
- There were different understandings among Commissioners regarding the process of drafting recommendations for the final report.

## FRIDAY, AUGUST 7, 2015

On Day 2, the Commission heard testimony from one panel and then held deliberations.

### **Leveraging Advances in Aviation and Patient Safety, and Public-Private Partnerships to Eliminate Child Abuse and Neglect Fatalities: *Dr. Mark Thomas, Senior Principal, Center for Transforming Health, The MITRE Corporation, and Edward B. Walsh, III, Associate Department Head, Aviation Safety Analysis, The MITRE Corporation***

Dr. Mark Thomas, of MITRE's Center for Transforming Health, opened the presentation by describing how MITRE's work in patient and aviation safety might apply to the prevention of child abuse and neglect fatalities. He noted the following:

- The complexity inherent in eliminating child abuse and neglect fatalities is one of the key reasons that these two panelists were interested in examining it.
- Similar to their work in aviation and patient safety, they 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.
- They 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.

Dr. Thomas described the unique status of MITRE, which is a private, independent, not-for-profit organization that manages federally funded research and development centers (FFRDCs) for a number of agencies, including the U.S. Department of Health and Human Services. MITRE's mission 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.

The federal government sponsors FFRDCs to address complex problems that require a high degree of objectivity and to do so without any conflicts of interest. Federal law and regulations allow FFRDCs to have access to sensitive information that would not be shared with other types of organizations. As the operator of FFRDCs, a large portion of MITRE's research occurs within independent research and development programs. One such internal research and development program has begun to examine child abuse and neglect fatalities by using aviation and patient safety as a model. MITRE is now beginning to partner with the health and human services agency at the County of San Diego to test this concept.

Edward Walsh presented on MITRE's aviation safety model. MITRE manages the public/private partnership among several federal government agencies and 45 airlines, as well as other labor and aviation organizations. He described the partnership's workings and characteristics:

- The partnership began in 2007 with the mission of facilitating the sharing of aviation safety data to conduct predictive analysis and identify emerging risk and systemic vulnerabilities before the next accident or serious incident occurs.

- Although the partnership is funded completely by the federal government, decision-making is collaborative.
- Data use is voluntary, and data include proprietary sensitive data collected anonymously.
- MITRE collects digital aircraft data on airline speed, altitude, and other factors on 95 million flights. Identifying information is removed.
- MITRE serves as the trusted third partner that collects and stores all the data and performs data mining and analysis, sharing results on a secure portal.
- Any airline employee can make a safety report, and data are wiped clean of any identity.

Walsh noted that a challenge in working with these data is the issue of standardization. The partnership had to develop a way to extract and convert the data from the native airline format to a unified format for use within the bounds of the partnership. The partnership also 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.

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 (1) ensure they are working as intended, (2) determine whether the risk in the system is decreasing, and (3) provide a benchmark for individual operators to compare their performance in the safety risk area to the rest of the industry.

Research studies generally result in one or more interactive dashboards to present the results to the community. The dashboards are hosted on a portal that serves as a secure gateway for the exchange of aviation safety information.

Walsh listed some of the lessons learned from the aviation safety model:

- Establish a joint government/private model.
- Give and take.
- Operate transparently in order to develop trust.
- Respect data ownership.
- Safeguard data.
- Provide serious stewardship.
- Provide valuable insights that would not have been possible without the partnership.

Dr. Thomas talked about MITRE's research on the prevention of deaths and injuries to patients at pediatric hospitals. He noted that medical errors result in 98,000 patient deaths and 181,000 injuries each year. To address this problem, MITRE established a public/private partnership with three leading pediatric hospitals. The partnership operates in the following way:

- The goal is to generate new knowledge about factors affecting patient safety that have not yet been identified.
- Similar to the aviation model, aggregate data are compiled to allow partners to establish benchmarks and measure their performance against the group average. Partners can view a safety analytics dashboard that allows them to customize and filter data.

- The MITRE-operated public/private partnership 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.
- 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.
- The types and amounts of data go far beyond what is traditionally reported to the government or other regulators.

Dr. Thomas suggested that the patient safety and aviation safety models could apply to the elimination of child abuse and neglect fatalities. If such a model were developed, it would depend on three building blocks:

- Developing trusted relationships between public and private partners
- Demonstrating value for stakeholders (e.g., states would need to see value if they were to invest in collecting and submitting data)
- Providing aggregated data and access to analytic tools and measures that help stakeholders achieve their objectives in a way that they would not be able to do on their own

Some of the challenges presented by child abuse and neglect fatalities resemble those faced by aviation and patient safety and include the following:

- Data related to child fatalities are heterogeneous and complex.
- Findings may not be generalizable to other situations or may rely on limited data.
- Data are often of poor quality and may not be easy to integrate with other data or be easily accessible.
- These data problems create challenges to the development of evidence-based measures or interventions.

Dr. Thomas described the way in which a MITRE-managed public/private partnership might be able to address the issue of child maltreatment fatalities:

- MITRE would be 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. MITRE would be the safe environment for data and would conduct research and analysis as directed.
- As the data were aggregated, the partnership could direct specific research studies on critical topics that could then inform policy and decision-making. The aggregation of data would provide an overview of child fatalities that the government or any single child welfare agency would otherwise never see.
- As the partnership matured, it might be able to generate new insights to allow for proactive intervention and provide a basis from which scarce or limited resources could target the highest priority needs. The hope is that this would then create an environment where the elimination of child abuse and neglect fatalities becomes possible.

## ***Commissioner Discussion***

The following points were made in the subsequent discussion between the Commissioners and the MITRE representatives:

- The federal government pays all of the costs of the public/private aviation partnership, which is about \$13 million per year, spread across several agencies.
- MITRE could help address child abuse and neglect fatalities by helping identify where areas of risk exist and what sort of limited resources should be brought to bear to address those risks.
- MITRE also could integrate data from different systems, such as criminal justice, Medicaid, education, and health to contribute to the analysis. Triangulation of data would help to make up for poor data quality in some cases.
- In order to address communities, such as Indian tribes, that do not collect data on child fatalities, the public/private partnership would have to demonstrate the value of the data collection.
- The public/private partnership between the government and airlines began with just a few airlines and grew gradually. That would likely be the case with child welfare agencies if a public/private partnership managed by MITRE were created.
- One possibility would be to begin with a pilot study with a limited number of counties partnering with MITRE.
- This approach might have real value in improving workers' decision-making.
- This kind of public/private partnership for child welfare data collection might improve not only child welfare data but also the data collected by other organizations, such as law enforcement.
- Local and national approaches are not mutually exclusive. Local approaches provide context, whereas national approaches provide more data and show trends.

## **Commissioner Deliberations: Disproportionality Subcommittee**

The Commission's Disproportionality Subcommittee distributed recommendations made by the speakers on the prior day's panel discussion about racial disproportionality in child welfare. The following points were made during the discussion:

- Racial disproportionality is not exclusively about minorities. It also may have a deleterious effect on white families when white children are underreported.
- The Sacramento statistic that shows that 80 percent of fatalities occur in six neighborhoods reinforces the argument for place-based strategies.
- A public health approach would incorporate place-based strategies, and it would be a nonpunitive approach.
- Implicit bias affects decision making and makes it less likely that minority families will seek help.
- There are many examples of mothers leaving their children with dangerous people, so the Commission may want to address the child care issue.

- In the United States, spending on senior citizens is determined at the federal level and consistent across the country, whereas spending on children is decided at the state level and wildly different from state to state; in addition, this country spends far less on children than other Western nations spend on their children.
- The use of a bench card to prompt workers to ask questions and engage families in a way that avoids bias could be useful.
- The Commission should make some strong statements and some recommendations about moving the needle on implicit bias in CPS, the courts, law enforcement, and other systems that interact with families.

### Commissioner Deliberations: The Final Report

Chairman Sanders opened the discussion of the final report by noting three factors:

1. The Commission's authority comes from Congress and is defined in legislation.
2. The Commission needs to fulfill its charge from Congress.
3. Individual recommendations are not going to answer that charge; rather, collective recommendations should be offered.

The charge from Congress was to respond in six areas:

- The effectiveness of services
- The effectiveness of policies and systems, especially, the most and least effective policies and systems
- Barriers to preventing fatalities
- Predictive factors
- Methods of prioritizing services
- Methods of improving data collection

The Commission then considered documents prepared by staff, including *Overview of Emerging Themes and Recommendations* (Draft 8.3; see [https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANFdraftreportThemes-and-Recs\\_OUTLINE\\_8.3.pdf](https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANFdraftreportThemes-and-Recs_OUTLINE_8.3.pdf)) as well as *Within Our Grasp: A National Strategy to Prevent Child Abuse and Neglect Fatalities* ([https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF\\_Proposed-National-Strategy-8-4-15.pdf](https://eliminatechildabusefatalities.sites.usa.gov/files/2014/11/CECANF_Proposed-National-Strategy-8-4-15.pdf)).

It was suggested that the Commission has the themes and the recommendations and now needs to focus on the story that will hold all of those things together. Four highlights to consider for the final report are the following:

1. Predictive analytics and using data as a tool
2. Multidisciplinary case and system thinking, as well as accountability
3. Real-time access to data
4. Targeting those children most at risk

A fifth item that might be a possible highlight would be the transformation of CAPTA.

The following additional points were made during the discussion of the final report:

- The most effective reports are those that have an overarching message and theme.
- There should be a public health approach that is a shared effort and goes beyond child welfare to include the young infants that die before they are known to any system and also multigenerational health concerns.
- There should be someone at a high government level, such as a cabinet level, who is responsible for children and children's services. This could mean the elevation of the Children's Bureau.
- CAPTA could be re-envisioned to transform the child welfare system.
- The final report should have a statement of principles up front, with a focus on safety.
- The report should have a dramatic headline followed by a dramatic proposal.

The meeting was adjourned at 12:36 p.m.

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



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David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities  
11/23/2015