



COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MEETING MINUTES February 26-27, 2015

Meeting Location: Portland Marriott City Center, 520 SW Broadway, Portland, OR 97205

Commissioners Present: Chairman David Sanders, Theresa Covington, Susan Dreyfus, Jennifer Rodriguez, Dr. David Rubin, Dr. Cassie Statuto Bevan, Marilyn Bruguier Zimmerman

Attending by Phone: Amy Ayoub, Bud Cramer, Wade Horn, Hon. Patricia Martin, Michael Petit

Designated Federal Officer: Liz Oppenheim, 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, February 26, 2015, from 8:00 a.m. to 5:30 p.m. and Friday, February 27, 2015, from 8:00 a.m. to 12:30 p.m. at the Portland Marriott City Center. The purpose of the meeting was for Commission members to gather national and state-specific information regarding child abuse and neglect (CAN) fatalities, including testimony on the following topics:

- Prevention of fatalities of children *not known* to the child welfare system
- Child welfare agency workforce issues
- Key federal policies aimed at protecting children
- The legal framework for child welfare

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 indicated that any audience members wishing to comment could submit testimony or written feedback through the Commission's website.

THURSDAY, FEBRUARY 26, 2015

Statement by Erinn Kelley-Siel, Director, Oregon Department of Human Services (DHS)

The meeting opened with remarks by Erinn Kelley-Siel, director of the Oregon Department of Human Services (DHS). She provided the Commission with insight about Oregon's efforts to protect children and prevent CAN fatalities. She focused her remarks on two themes:

- Preventing CAN fatalities is a responsibility that extends beyond the formal child welfare system.
- When a fatality does occur, it is important for child protective services (CPS) to demonstrate transparency and accountability, learn from its mistakes, and implement a response system that is committed to system improvement.

Director Kelley-Siel reported that Oregon recorded 10 CAN fatalities in 2013, none of which had any prior child welfare history. The primary risk factors contributing to these 10 fatalities were identified as drug-use, co-sleeping or bed sharing, guns in the home, the religious beliefs of parents, and the parents' own history of victimization or other trauma.

She noted that DHS convenes a statewide fatality review process twice a year, in partnership with public health. Through this joint process, officials have been able to identify trends and work together on prevention strategies. Recent joint efforts resulted in:

- A “targeted conversation” with medical providers and early childhood professionals about reducing the number of young children dying from co-sleeping
- A coordinated data collection and reporting system on child fatalities that relies on surveillance data beyond the child welfare system
- Growing partnerships with drug and alcohol treatment providers, working toward expanding the focus on family-based treatment
- Co-location of domestic violence advocates in state child welfare and self-sufficiency offices

Additional key points about state partnerships include the following:

- State data reveal that many of the children and families coming to the attention of child welfare are recipients of benefits through the Temporary Assistance for Needy Families (TANF) program. Kelley-Siel suggested that the TANF program should be seen as serving a dual purpose—as an employment program for parents, but also a child-serving program that creates family stability and helps to prevent CAN.
- Oregon also is pursuing a stronger early learning system that incorporates parent training, home visiting, developmental screenings, and training for child care providers. Programs and services within the early learning system can aid in keeping children safe, in part, by helping families build social capital and reduce isolation.

Oregon began to convene Critical Incident Response Teams (CIRTs) within 24 hours of certain child fatalities in 2004 (required by state statute since 2007). A CIRT is required when a child with a current connection to the child welfare system—or one who has touched the system in the previous 12 months—dies or is seriously injured. Thirty-five CIRTs have been convened since 2004. Oregon posts the resulting reports publicly, including findings and recommendations related to improving the state's child protection efforts. The following are some of the practice changes that have resulted:

- Practice model changes that increase the emphasis on child safety
- Incorporation of a strength-based practice model in working with families, while also moving toward an emphasis on behavior change, rather than compliance
- Improved communication between caseworkers and systems
- Enhancements in the content and quality of data collected and analyzed
- Reinforcement of the critical role of mandated reporters
- Setting an expectation for specialized medical examinations and consultation to better identify child abuse and neglect

Kelley-Siel noted that some child welfare workers were initially wary of the CIRT process. It was important to demonstrate that the CIRTs are not about punishing or assigning blame, but instead are a way to improve the system and build trust with the public.

She identified four challenge areas that she believes warrant the Commission's further attention:

- **Interstate access to information on vulnerable families.** She cited the inability of child welfare agencies to access information about families that travel between states as a significant challenge that has been demonstrated in several CIRTs.
- **Social isolation of families.** Too many families are detached from extended family and community resources at a critical and stressful point in their lives. Of particular concern are families that have previously been engaged with providers and services, but who fall off the radar and are rediscovered only after a child dies.
- **Cross-system information sharing.** There remain serious constraints to sharing information between systems and partners involved in the life of a child and family. Kelley-Siel noted particular challenges in sharing information between child welfare and behavioral health.
- **Prevention funding.** Prevention funding must be better prioritized. Director Kelley-Siel suggested that enhancing parental capacity and family economic stability will be key to preventing trauma. She noted that it remains critical to invest in both prevention and the response system for when a child is abused; the key will be striking a balance.

Commissioner Discussion

In response to a Commissioner question, Director Kelley-Siel later clarified that of the 10 deaths in the state during 2013, there had been no child welfare contact with any of the families in the 12 months preceding the deaths, but six families had some contact with the system before that.

A Child Well-Being Framework, Implications and Lessons for Child Fatality Prevention: Panel Presentation

This panel focused on innovative service delivery models in the Pacific Northwest, specifically looking at cross-system data-sharing, funding, and program efforts that prevent child maltreatment fatalities.

MaryAnne Lindeblad, Director, Washington State Health Care Authority, Washington State Department of Social and Health Services

MaryAnne Lindeblad spoke of the long history of collaboration in Washington State between child welfare and Medicaid. The state's Fostering Well-Being Team brings together nurses, pediatricians, and case managers to support caregivers and social workers and ensure timely access to medical care for children in the child welfare system. There is a framework in which health is more than just health care. Their work includes:

- Use of a predictive risk tool, PRISM, to identify and coordinate services for children with health needs
- Services that include support for pregnant women, including substance abuse treatment
- With the Affordable Care Act (ACA), expansion of broad-based insurance coverage for parents up to 138 percent of the federal poverty level to reach families not traditionally eligible for Medicaid
- Efforts to build integration of behavioral health and physical health through care coordination services
- Accountable Communities of Health across the state, with a goal of whole-person care and a fully integrated delivery system by the year 2020
- Use of evidence-based and promising practices such as Triple P, trauma-informed care, and routine second opinions about psychotropic medications
- Reform of payment systems and access to data and analytics

Amy Baker, Children’s Mental Health Director, Addictions and Mental Health Division, Oregon Health Authority

Amy Baker spoke of the impact of adverse childhood experiences (ACEs) on brain development of young children, ages 0 to 5 years. This is a public health problem and the bottom line is: Healthy families raise healthy kids, and healthy communities foster healthy families. In Oregon, they are taking the following steps:

- Creation of children’s health policy teams that include public health, mental health, Medicaid, early education, and developmental disabilities systems
- An effort to include community and family voices in policy
- An approach that addresses the multigenerational impact of ACEs and poverty
- Development of coordinated care organizations (CCOs) that have one budget for all health care services
 - CCOs have a cap on spending and there are no siloed budgets.
 - They use predictive analytics to target high-risk families.
 - Health care costs have been reduced and funds can be reinvested in prevention.
- Parent-Child Interaction Therapy (PCIT) is implemented in 16 counties to coach parents in the ability to recognize their children’s cues and respond appropriately.
- Nurse-Family Partnership has been rolled out across the state and prioritizes children ages 0 to 3. The program includes attention to mental health issues such as family environment and stress.
- The former governor’s emphasis on early learning helped create a system of care for young children in which multiple partners have the ability for early intervention.

Helen Bellanca, Maternal and Child Health Program Manager, Health Share of Oregon

Helen Bellanca spoke in more detail about Oregon’s CCO model as an accountable care model of health transformation. One global budget covers physical health, mental health, and dental care. There are 16 CCOs in the state, organized geographically. Bellanca works for Health Share of Oregon, one of the largest CCOs, which is based in the tri-county area around Portland. At Health Share:

- 47 percent of the members are children or adolescents.
- They take a preventive approach that looks at how physical, mental health, or addiction challenges can derail an adult’s life and thus threaten a healthy life for their children.
- Prevention efforts begin with pregnancy and follow children up to age 6. Maternity care includes behavioral health care, mental health, domestic violence, and addiction treatment.
- Prevention begins with a focus on contraception and prevention of unintended pregnancy. Oregon is the first state in the country to have a quality metric on contraception care.
- Once a woman is pregnant, a family well-being assessment is used to identify issues that could put the family at risk for child abuse or neglect.
- Critical factors in their success include integrated systems, a global budget with pay-for-performance metrics, contraception as preventive health care, and the fact that maternity care is a key touch point for reaching parents around a host of social and health issues related to child abuse and neglect.

Commissioner Discussion

Commissioners and panelists made the following points in discussion:

- In implementing upstream initiatives like those in Washington and Oregon, what finance and regulatory actions can give communities the flexibility to sustain their innovations? A fee-for-services model gets in the way of innovation. The ultimate goal is fees for *outcomes*, but Oregon is not there yet.
- Another suggestion was to have a global budget for all children’s programs federally, which could alleviate the effort of working across specific federal programs.
- Investment in innovation, including start-up funds and incentive payments, is important.
- Oregon agreed to cap funds in their global budget and to reduce the rate of growth of spending. Leaders believe integrating physical health, mental health, and addiction treatment will yield savings.
- The nine tribes in Oregon elected not to join the CCOs and continue to bill the state directly for services. But tribes were receptive to a conversation about contraception and preventing unwanted pregnancies.
- Looking at an intergenerational approach is important, with attention to the second or third generation of parents in the system. Oregon’s CCOs have adolescent wellness visits that include risk and asset assessments and look at mental health, substance issues, and the need for contraception. The goal is to interrupt the cycle of ACEs. However, there is no specific program yet that proactively targets adolescents from intergenerational families.
- Washington State has an integrated database that includes Medicaid, education, criminal justice, and child welfare. It is a work in progress as they decide what to measure and how to use the data.
- CECANF is focused on child fatalities. If systems move to a family-centered approach, what research is there to show that this will support child safety and eliminate fatalities? Looking at the key drivers—mental health, addiction, and domestic violence—will be important and can have a big impact on fatalities. No one system can fix the problem.

Child Welfare’s Capacity to Prevent Fatal Maltreatment: Workload and Workforce Turnover as Factors in Preventing Fatal Child Maltreatment: Panel Presentation

This panel explored the research on agency workload factors that influence performance, with a specific focus on variables such as time allocated to investigation and safety and risk assessment, frequency of case manager contact, duration of contacts, and quality of contacts. It also explored the issue of workforce turnover and its impact on child and family outcomes, particularly the prevention of fatalities.

Myles Edwards, Independent Consultant

Myles Edwards testified that there is no definitive data that links workload to outcomes; workload alone is likely not directly related to outcomes. Rather, the practice model and its implementation are the key factors affecting outcomes for children and families. His remarks included the following:

- It is important to keep the focus on what children and families need and to configure staff based on that. This is a client-centered perspective on workload.
- One metric to look at is how much time a worker needs to do case-related or practice-model activities vs. maintenance issues.
- If states expect workers to do work that is not possible in the time allotted, they’re setting up for failure.
- He supports workload monitoring rather than workload studies.

Don Graham, Walter R. McDonald and Associates

Don Graham referred to workload studies as a tool, not an end in themselves. His key points included the following:

- The purpose of workload studies is to improve practice and understand the resources needed to support children and families. Studies measure an agency's response to abuse, as well as measuring and assessing the gap between workload and resources.
- Workload studies have not specifically addressed impact of workload on CAN fatalities. The most relevant outcome studied in most workload studies is the reoccurrence of abuse or neglect.
- Workload studies give the agency an opportunity to look at how workload influences implementation of their practice model and allow management to develop alternatives to simply adding staff, such as partnering with other systems or adding new methods or technologies to the practice model.

Ryan Vogt, Oregon Department of Human Services

Ryan Vogt discussed Oregon's workload model. Many people believe child welfare is under-resourced, but with the research currently available it is difficult to know whether that is true, or if true, *how* under-resourced it is. Key points include the following:

- In 2008, 2010, and 2014, all of the state's child welfare caseworkers did a three-day survey documenting their activities. These workload studies show where workers actually spend their time: what gets done, how much time is spent on it, and what does not get done.
- A traditional caseload model is based on a fixed amount of work that assumes family problems do not increase in complexity over time and that the service array remains the same.
- The legislature in Oregon was more used to caseload models than workload models. But the workload studies showed a larger gap between workforce and workload than the traditional caseload model had shown. These studies generated a more nuanced conversation with the legislature about what investment is needed to reach goals and how to be more efficient.
- As a result, the legislature invested in additional staff.
- The department focused on training, efficiency, and streamlining their business, as well as asking caseworkers and front-line staff to suggest opportunities for improving the work.

Joan Zlotnik, Director, Social Work Policy Institute, National Association of Social Workers (NASW) Foundation

Joan Zlotnik pointed out a number of workforce issues that affect the delivery of child protective services and impact children's safety. She specifically looked at training and retention. Key points:

- There is little specific research on the education and training of child welfare workers. One national study showed that less than 40 percent had a bachelor's or master's of social work (B.S.W. or M.S.W.).
- Research shows that workers with social work degrees are more effective in achieving permanency, visit more frequently, use community resources better, and target services more accurately to the level of severity or risk for future abuse or neglect.
- Much of the current research has focused on retention. It has shown that both personal factors and organizational factors are involved.
- Workers are expected to make quick judgments about safety and risk in situations that can cause emotional stress. They need knowledge and skills for this.

- Often workers do not have the clinical training and assessment skills to perform the jobs they are hired to do, especially around implementation of evidence-based interventions and understanding issues such as substance abuse, maternal depression, and other risk factors.
- Title IV-E training dollars cannot be used to train for clinical skills or for CPS investigations.
- There has been a lot of research about the impact of supervision; it has been shown to affect goal attainment, assessment engagement, client satisfaction, worker competence, and job satisfaction for workers, which in turn affect retention.
- High rates of turnover are a great concern and are costly on numerous levels. Some turnover rates are as high as 50 percent. Research shows that turnover can affect outcomes such as placement stability, although there is no research that looks directly at the impact of staff turnover on fatalities.
- Workload studies in several states have called for more workers.
- In doing fatality reviews, there is a need to look at how many workers a family had, how much education and training they had, and how long they had been on the job.

Commissioner Discussion

Commissioners and panelists made the following points in discussion:

- Caseload and workload issues come up regularly when there is a child death, but the issue is complex. Should states be talking about caseload or workload? Do standards refer to families or children? There is little consistency. The Child Welfare League of America has standards, but they are not recent. NASW does not have a national standard caseload for child protection workers.
- Workload stressors in Indian Country are unique and include huge staff vacancies and expansive distances to travel. In addition, workers on tribal lands are often members of the tribe and must work with their own relatives in their own communities, an added stressor.
- Should the Commission make a recommendation around workload studies to include frequency and best practices for conducting the studies?
- How can workload studies support implementation of practice models? Where does prevention fit in, and who owns it as part of the workload?
- There are approximately 250 MSW programs in the country, with an unspecified number that include a specialty track for public child welfare.
- In research on retention, supervisory support is more important than caseload. But reasonably sized caseloads are important in implementing practice models with fidelity.
- Workload varies according to the dynamics of each case.
- There is no proven correlation between lower caseloads and child fatalities.

Federal Child Welfare Policies Focused on Child Safety: JooYeun Chang, Associate Commissioner, Children's Bureau, Administration for Children, Youth and Families, U.S. Department of Health and Human Services

Associate Commissioner Chang outlined the work of the Children's Bureau and its partners at the U.S. Department of Health and Human Services (HHS), using her time before the Commission to:

- Provide some context for the work that the Children's Bureau has done or is currently doing related to CAN fatalities.
- Outline existing or forthcoming prevention strategies.
- Identify lessons learned to help inform the Commission's work and recommendations.

- Outline policy considerations, within and beyond the President’s Fiscal Year 2016 Budget.

She began by defining the mission of the Children’s Bureau: “To improve the overall health and well-being of children and families, but particularly vulnerable children and families.” The Bureau provides financial support, guidance, and technical assistance in three primary areas:

- Strengthening families and preventing CAN
- Protecting children when CAN has occurred
- Ensuring every child has a permanent family or family connection

Chang retraced earlier efforts to better understand and outline strategies to prevent CAN fatalities, including the 1995 report of the U.S. Advisory Board. Among the findings in 1995 was a lack of knowledge about the scope and nature of CAN fatalities. Chang noted that this is still a struggle. However, progress has been made in the following areas:

- Enhancing joint training on identification and investigation of CAN fatalities
- Development of child death review teams in all 50 states (including the creation of the National Resource Center for Child Death Review)
- Identification of child safety as a goal in federal and state legislation, and as part of the Child and Family Services Reviews (CFSRs)
- Expanding access to a fuller array primary prevention services, including home visiting
- Integrating services and providing interagency training on the connections between child abuse and domestic violence
- Relying on more varied sources of data to measure CAN fatalities

Associate Commissioner Chang suggested that the number and variability in types of reviews that can occur after a child dies or nearly dies complicate determinations of what is and is not a CAN fatality. These include child welfare agency reviews, fetal and infant mortality reviews, and domestic violence fatality reviews, among others.

Chang then discussed several efforts funded by the Children’s Bureau that have supported prevention of CAN fatalities, including the following:

- Children’s Justice Act funding to improve the response to and investigation of CAN fatalities, including fatality review teams and training of coroners
- Technical assistance, through the National Resource Center for Child Protective Services, in implementing safety assessment tools with fidelity
- Community-Based Child Abuse Prevention (CBCAP) grants to identify and support protective factors
- Discretionary grants (including support of home visiting and the Quality Improvement Center on Early Childhood)
- Regional Partnership Grants to promote partnerships between child welfare agencies and substance abuse treatment providers
- Grants to investigate the effectiveness of supportive housing for families in the child welfare system
- Development of an annual Prevention Resource Guide
- Coordination of the Federal Interagency Workgroup on Child Abuse and Neglect

Chang highlighted two reports to Congress to be released in 2015 that might be of interest to the Commission: one looking at the feasibility of collecting data specific to shaken baby syndrome, and

another that examines the degree to which federal and nonfederal partnerships are able to effectively coordinate efforts related to child abuse and neglect.

The Associate Commissioner then discussed several specific opportunities for the Commission to consider as it moves forward:

- **Near fatalities.** Chang called near fatalities a “crucial area that needs further investigation.” One challenge is that what is meant by a near fatality is not consistently understood. CAPTA defines *near fatality* as an act certified by a physician that “places a child in serious or critical condition”—defining it by the effect on the child, rather than the act itself, which differs from other data collected by the child welfare system. Also, there is not agreement on what constitutes a “serious condition.” Chang emphasized that more consistent identification of near fatalities will require a close partnership between medical professionals and CPS.
- **Working across federal agencies.** CAN fatalities are an issue of interest to both child welfare and public health agencies; solving this issue will require a joint effort.
- **2016 budget proposal.** Chang ended her comments by providing an overview of specific FY 2016 budget proposals that may impact this issue. They include the following:
 - A \$5 million CAPTA grant to develop better models of investigation of child abuse and neglect reports to reduce disproportionality and CAN fatalities
 - An amendment of title IV-E that supports investment in evidence-based prevention and postplacement services for children who are at risk of entering foster care
 - Modification of the Abandoned Infants Assistance program to focus more broadly on infants and young children
 - Expansion of the service array in rural areas
 - Support for greater reliance on family-based care for children in or at risk of placement in congregate care
 - A reduction in the utilization of psychotropic medications for children and youth in foster care
 - Extension of Chafee supports for youth up to age 23
 - Grants to help prevent youth in foster care from becoming victims of human trafficking and provide better services for victims
 - Investments to assist tribes in building the capacity of their child welfare programs

Commissioner Discussion

The following key points emerged from follow-up questions by Commissioners:

- There was some discussion of the possibility of more extensive waivers that would allow braiding of different funding streams (e.g., Medicaid and child welfare) and aid in shifting the focus upstream to prevent more children from experiencing CAN. Associate Commissioner Chang noted the success of the title IV-E waivers in directing more funding to prevention and postpermanency services. She emphasized that although flexibility is important, there also is a need to maintain entitlements. She pointed out that child welfare has a more limited focus than Medicaid; not all poor families in need of health care abuse their children.
- When asked why states are not required to submit data to the National Child Abuse and Neglect Data System (NCANDS), Chang pointed out that the law states that this reporting is voluntary. Upon further questioning, she noted that any such mandate would need to be accompanied by commensurate funding to support states’ compliance with the law.

- The only current measurement of safety in the CFSRs is re-entry into the system. Those reviews are limited to data available in the Adoption and Foster Care Analysis and Reporting System (AFCARS). There is a current proposal to update those data elements.
- The Children’s Bureau has historically provided technical assistance through a network of National Resource Centers around specific topics; they now have one umbrella organization that works with states more comprehensively on capacity building and evidence-based practice. The Bureau does not promote a specific practice model.
- Associate Commissioner Chang is not aware of any prior effort to streamline the “web of reviews,” but this may be an area to explore with the Federal Interagency Work Group.
- Chang is not aware of any prior effort to standardize the definition of children “not known to the child welfare system” who have died from child abuse and neglect.
- Regarding the subject of measurement, Associate Commissioner Chang noted that no matter how accurate the national count of CAN fatalities becomes, the *N* will always be small. She suggested that whether or not the count is accurate may not be the most important question. Instead, time might be better spent on providing effective prevention strategies that help those children and families known to be most at risk.
- Regarding what information is to be made available to the public when a child dies or nearly dies from child abuse and neglect, Chang assured Commissioners that the administration values transparency. Still she acknowledged that transparency must be balanced against the need to protect the child’s interests. Agencies also are legally bound to abide by the Health Insurance Portability and Accountability Act (HIPAA).

Understanding the Legal Rights of Government and Citizens Regarding Intervention on Behalf of Children: Limits, Challenges, and Opportunities: *Kathleen Noonan, Co-Director, PolicyLab, Children’s Hospital of Philadelphia*

Kathleen Noonan addressed the Commission to advance an understanding of the role of individual and state rights and how these rights may clash and be reconciled. This information was intended to inform and support Commissioners as they begin to draft specific recommendations. Key points from her presentation include the following:

- Individual rights come from the 5th and 14th Amendments; states cannot infringe on a person’s life, liberty, or property without “due process of law.” The Supreme Court of the United States has provided examples of liberty rights, which include the right to marry, procreate, and direct the education and upbringing of your children.
- In a pivotal case for child welfare known as *DeShaney v. Winnebago County (Wisconsin)*, the state did not intervene, even though the child was hurt. The Supreme Court ruled that there wasn’t a constitutional right to protection from harm from the state. This case illustrates that parental rights are very broad. On the other hand, the court said there was nothing in this case decision to limit a state from putting in place protections for children via state statutes.
- As shown in *Cruzan vs. the Director of the Missouri Department of Health*, adults have the right to consent to treatment, including mental health treatment. This right extends to parents’ rights to determine what happens to their children.
- There are exceptions to these rights, including imminent harm, medical emergencies, and compulsory education. The latter exception may prove particularly instructive to the Commission’s work and recommendations, because it suggests that the state has a greater ability to trump parental consent if the proposed intervention is more universal rather than directed at a targeted segment of the population.

- There are three ways the state can step in and take action to protect the rights of its citizens: protecting people from harm, substituting judgment for a person who is ruled incompetent, or making a decision for citizens because it is in their best interest.
- When individual and state rights clash, judges apply fact-based balancing tests. In the case of a compelling state interest, the court will seek to apply that interest in the most narrowly defined way that produces the “least intrusive interference” with parental rights. (For example, the Amish had challenged compulsory education requirements. The courts attempted to find a balance by creating an exception that requires Amish children to attend school only until they are 14 years of age.)
- If states are going to interfere in a fundamental right, such as the right to parent, evidence of harm (and/or the public good) is extremely important to the case.
- Another balancing test relates to the best interest of the child, which will be important to understand as discussions of threat of harm unfold. Again, heavy data analysis will be necessary.
- The final balancing test speaks to protecting the public health. Here, the state must show a substantial relationship to the impact on the public’s health as they seek to override individual consent rights. (An example is compulsory vaccination.)
- Balancing tests are fact-dependent and can vary based on local norms. For example, some states have decided that a child witnessing domestic violence is per se child abuse, whereas other jurisdictions have not.
- Recently, with regard to child welfare, balancing tests seem to be tipping in favor of the state, rather than parents’ rights. The definitions of what is seen as child abuse and neglect have expanded in recent years. On the other hand, so have requirements for efforts to reunify families.
- Noonan offered several frameworks to consider while Commissioners are drafting their recommendations:
 - **Universalism vs. segmentation.** Universal programs are less likely to infringe upon one person’s individual rights. Creating a program for a segmented population is possible, but it will require more data and evidence.
 - **Preemptive intervention vs. reactionary intervention.** Preemptive intervention may need to occur outside of the child welfare system, whereas a universal program can be created that is based on threat of harm or the best interest of children.
 - **Mandatory vs. voluntary.** Currently, the problem with prevention programs within child welfare is that they are not mandatory.

Commissioner Discussion

The following key points emerged from follow-up questions by Commissioners:

- Predictive analytics may prove to be a useful tool in child welfare, but because it segments populations, it will require considerable evidence if challenged in court. That evidence is not yet fully established.
- Federal and state laws related to drug-exposed infants were addressed. Some jurisdictions do identify these infants under a “threat of harm” standard, but child welfare workers often are unsure whether to take children into foster care, especially if the mother is functional and involvement with CPS may undermine her treatment.

CPS Subcommittee

Commissioner Rodriguez began the subcommittee presentation on children that are known to the child welfare system. She noted that the recommendations presented focus exclusively on one area: safety assessment. The subcommittee eventually will be making additional recommendations in other areas (e.g., workload, confidentiality, agency practices, resources, accountability) but chose to start with safety assessments because they are critical and central pieces of the role of the CPS agency.

The Commissioners began by reviewing a recent case from Florida that highlights some of the critical issues around safety assessment. Key points raised include the following:

- Phoebe Jonchuck (age 5) was dropped from a bridge by her father, fell 60 feet, and drowned. The Jonchuck family was known to many systems, likely for generations, yet CPS did not have a specific incident to respond to on this day. Two calls had been made to CPS regarding the family in the days leading up to her death, and there was an open CPS case involving the mother.
- This case highlights the challenges of cases where there is an impending (but not present) threat to child safety, as well as the importance of sharing information across systems.
- The objective in looking at this case is not to be retrospective or to criticize the actions or decisions made in Florida. Instead, this case is used to raise a number of issues regarding the threshold for threat of harm.
- There were multiple possible prevention pathways that failed, including DCF involvement with the father as a child, mental health involvement with the father as an adult, repeated arrests by law enforcement for battery and domestic violence, and family court involvement in custody issues.
- The hotline response (screen out) indicates the orientation of the CPS system: There was no harm occurring right at that point in time, so it was determined that no response was needed.
- This is part of a subset of cases (similar to murder-suicide) that the Commission has not yet addressed. These cases seem impulsive, but there are risk factors for mental illness and suicidality that can be identified. It's also an issue of limited resources; CPS agencies are drawing fine lines in difficult situations.
- In a present-danger model, the child would not have been viewed as being in danger in that moment. But in an impending-danger model, something would have to be done, because the circumstances were unpredictable and could change at any time.
- This case also speaks to the "tunnel vision" with which systems view cases. Law enforcement had investigated, but they concluded that the father had made no verbal threats against himself or anyone else.
- It raises some questions about how hotline calls are handled, particularly those from mandatory reporters. Children deserve more than a single person taking a call, and making a screening decision. It also underscores the importance of staff qualifications and training.

Commissioners then turned to a review of key findings and themes from presentations heard to date. A few of these were highlighted during the meeting, including the following:

- Safety assessment is a challenging, critical task is currently not being done in a multidisciplinary way.
- There is no research on the effectiveness, fidelity of implementation, or interrater reliability of safety assessment tools that are currently in use.
- Safety assessment typically looks at a single point in time; tools are needed that can be used at multiple points throughout the life of a case.

- The present-danger orientation of current safety assessment instruments does not identify impending or emerging danger or help with evaluating prospective safety.
- There is a lack of effective training in safety assessment for child welfare staff.
- All states require cross-reporting of child maltreatment with law enforcement in some cases, but little is known about when or how cross-reports actually occur. (The Electronic Suspected Child Abuse Reporting System [ESCARS] in Los Angeles was highlighted as a promising practice that supports real-time cross-reporting.)

Commissioners then discussed recommendations for federal, state, and local policy, research, and practice. Federal themes focused on the need for more research on risk factors and effective safety assessment protocols and procedures.

The following key points were raised in response to the proposed recommendations:

- Recommendations need to be more actionable, spelling out who would be responsible for each. Some of this may be covered in the state plans being proposed by the Public Health Subcommittee; those may include a safety component. The state plans as envisioned would establish overall goals and guidelines but offer states flexibility to determine how they are going to meet those requirements. The federal role also might include providing guidance from research about risk factors and/or evidence-based practice.
- The focus of accountability needs to be more at the federal level, if child protection is not to be an “accident of geography.” This must be balanced with the fact that there is not yet enough evidence of what is effective to say, “everyone should be doing this everywhere.”
- Federal law cannot supplant state law, but the Commission could establish guidance (in law, such as title IV-B), fund it, and hold states accountable.
- Rather than building in more guidelines for the current CPS/child welfare structure, the Commission may want to look at a new way to structure the system that is more effective.
- There is a desire to move services “upstream,” to a primary prevention/public health approach. However, there always will be children who are at risk, so the need to respond to CPS calls will always exist. There is concern that moving services upstream must not rob children at the highest risk of the services they need.
- Safety assessment is weak across all service sectors, not just CPS; increased partnership may not adequately address the question of safety. The concept of proactive safety management (done in other industries, such as aviation) is worth investigating/considering.
- One way to get things to change is to create an incentive (e.g., ASFA created a system for rewarding states that increased adoptions over the previous year).
- States tend to do what is measured. One recommendation might be for certain things to be reported on by all states. Right now this is done only for children in the out-of-home care system (AFCARS). The federal government needs to do a better job of telling states what they need to report on related to child safety.
- Joint efforts by (and communication between) child protection and law enforcement are critical.
- Future risk to the child is often misjudged based on the severity of a current injury. Front-line social workers may not have enough knowledge or training to evaluate all aspects of a case. This is why it would be helpful to have a second level of safety assessment/review that looks at less serious cases in the context of factors that might not be immediately obvious.

For next steps, the CPS Subcommittee was asked to consider the following:

- Meet with the Public Health Subcommittee to work toward a shared vision.

- Give further thought to the role of the federal government vs. state/local governments.
- Look at information sharing and the degree to which the Commission should support the evolution of predictive analytics for triage within the system.
- Consider how a universal safety assessment could be created across federal agencies that touch families, such as the Bureau of Indian Affairs.
- Flesh out an overview of safety and safety assessment requirements in federal law.
- Look at whether some of the recommendations currently proposed for state/local governments could be revised to address the federal government.

American Indian/Alaska Native (AI/AN) Subcommittee Update

The AI/AN Subcommittee presentation included the following key points:

- There will be a special meeting on Tribal issues in March in Scottsdale, Arizona, at the Talking Stick Resort. Commissioners will have an opportunity to visit the Salt River Pima-Maricopa Indian Community Family Advocacy Center the day before the meeting. The meeting will include presentations by national experts on jurisdictional issues, data collection, child welfare practice, early intervention, and the federal role.
- At this meeting, Commissioners will hear from national Native organizations, national Native technical assistance providers, Tribal leadership, and U.S. attorneys.
- The Commission has heard previous testimony that AI/AN children are not dying from abuse but are experiencing higher levels of neglect. Reliable data do not exist to prove or disprove this.
- The meeting also will look at disproportionality of Native children in foster care and potential ways to address this issue.
- Subcommittee members will be traveling to Washington, DC to meet with officials from the Bureau of Indian Affairs (BIA) and Indian Health Service (IHS), along with other federal officials charged with serving AI/AN children and families.

FRIDAY, FEBRUARY 27, 2015

Policy Subcommittee

Commissioner Statuto Bevan began the discussion with an overview of the Policy Subcommittee's charge, which focuses on four areas:

- **Clarification:** Identifying the specific social policy problem that the Commission is examining (CAN fatalities). This includes defining what is known about victims and the circumstances of their deaths, and what gaps in knowledge currently exist.
- **Effectiveness:** Studying the effectiveness of existing policies and services. This effort will focus primarily on titles IV and XX of the Social Security Act, and CAPTA. The subcommittee will conduct detailed analysis of policies specific to achieving safety goals for at-risk children. These include:
 - Child fatality review
 - Plan of safe care (per CAPTA)
 - ASFA's requirements for termination of parental rights
 - The "aggravated circumstances" exemption to reasonable efforts within ASFA
- **Accountability:** Examining policies and laws to determine whether states are ensuring that safety is addressed, with a focus on the following:

- The requirement in title IV-B that safety is paramount
- CAPTA requirements for safety assessments and prompt investigation reports
- Infant safe haven laws
- **Efficiency:** Identifying gaps and duplication of programs, to examine the current allocation of funding and opportunities to strengthen and improve. Action steps include:
 - An inventory of current federal programs to identify existing federal authorities and accountability relevant to child safety
 - Examination of collaboration and coordination among public agencies

The subcommittee will not make its own recommendations but will review emerging recommendations from other subcommittees based on these four principles.

Discussion

Key points of discussion included the following:

- Ways to enhance enforcement of CAPTA penalties for noncompliance were explored—these penalties have not been applied to date around plans of safe care for drug-exposed infants. If CAPTA has not been effective in this respect, what other avenues would be more effective?
- The CFSRs are supposed to assess the child welfare system as a whole, and this process does look at outcome measures. The CFSR penalties come from states’ title IV-E money and are significant. The federal government could do more to improve transparency as states are preparing for their CFSRs. Also, Commissioners wondered what the responsibility of the governor is when state performance improvement plans (PIPs) have implications beyond child welfare, across systems.
- Some Commissioners questioned why infants exposed to alcohol are not included in the “plan of safe care” requirement. Fetal alcohol syndrome has a more significant impact on children’s brain development than cocaine exposure. It’s also possible to look at drug use as a signal for other risk factors for fatalities, such as co-sleeping.
- There was discussion about the relationship between child fatality review teams and rapid response teams (RRTs, within 24 hours). There is no specific federal requirement for RRTs; states can choose from among several different types of reviews. Nor is there any federal funding for fatality review processes.
- There was discussion about the feasibility of minimum federal standards for child death review teams and definitions of terms such as “safety” and “near fatality.”
- Commissioners agreed that one or two subcommittees (including Policy) should look at the recent *Shame on U.S* report to review and assess the recommendations made regarding federal accountability.
- Commissioners raised questions about the role and charge of the Federal Interagency Work Group on Child Abuse and Neglect. Could this be expanded to enhance accountability around this issue at a federal level? Congressional oversight is another potential accountability measure that was explored.
- Commissioners considered a different approach to noncompliance, in which a failure of a state to comply with regulation triggers a technical assistance response, or a combination of technical assistance and funding penalties, to help states get to the goal more quickly.
- The Policy Subcommittee will look at the issue of child welfare finance reform without endorsing a specific recommendation. The Commission needs to acknowledge that every state visited so far has asked for greater flexibility in funding. The subcommittee will explore options for a “block grant with principles,” as well as any barriers in federal law to creating

greater flexibility. It was agreed that any proposals must be tied specifically to the Commission's charge of reducing fatalities.

- Before specific proposals about funding can be made, the Commission needs to learn more about what approaches work best and what gaps (if any) currently exist between the resources needed to address the problem and those currently available. The AI/AN Subcommittee will have specific recommendations about funding for tribes, who are currently significantly underfunded.

Public Health Subcommittee Report

Commissioner Rubin, supported by staff lead Sarah Zlotnik, presented the subcommittee's working paper that highlighted goals, vision, questions, and themes for recommendations. Commissioner Rubin pointed out the urgency of elevating the issue of CAN fatalities, so that it does not sit in one division of one part of government. The subcommittee listed four key directions or themes to frame their suggested recommendations and proposed greater visibility for Medicaid in terms of implementation:

- Require states to develop and implement a comprehensive state plan to prevent child maltreatment fatalities. This is a cornerstone recommendation that would bring different systems to the table together to plan, implement, and share accountability. The Commission could provide guidance around elements that must be included and who needs to be part of the planning and implementation process.
- Leverage opportunities in different public systems to improve identification of children and families at risk. The health care system is key here because it is one of the few systems that touch almost all young children. Specific opportunities include the following:
 - Use health information exchanges to identify red flags.
 - Develop new pediatric quality measures.
 - Improve ER screening.
 - Ensure that behavioral health is part of early screening and treatment.
 - Enhance risk screening in prenatal care and well-child visits.
 - Provide better federal guidance around permissible use of Medicaid funds to support at-risk children.
- Ensure access to high-quality prevention and intervention services. These services should be identified upstream, with particular attention to ACEs such as substance abuse, domestic violence, and mental health.
- Enable more flexible funding to support place-based strategies and to better integrate and align cross-system efforts. This would include Medicaid and government grant opportunities.

Commissioner Discussion

The following key points were raised by Commissioners in response to the subcommittee's report:

- What is the best way to support states in developing and implementing such a plan? (Possibilities discussed included funding options such as Medicaid and the Maternal and Child Health budget.) The solution will need to go beyond reform of title IV-E funding.
- This is a population-based approach, not just an individual child approach. The medical analogy is a public health approach vs. an emergency room approach. It is a public health, cross-sector approach that needs to include the interface of CPS, law enforcement, education, and the medical community as they interact with individual children at risk.
- How can an intergenerational response be generated to support young parents who were themselves in the system?

- Coordination between the CECANF Child Protection and Public Health Subcommittees is critical in terms of developing recommendations.
- Data-driven planning is more effective than media-driven planning.
- The Commission should be mindful of including tribal people in planning and funding.
- How to ensure that hotline calls from medical practitioners do not lead to racial or ethnic disproportionality?
- How to ensure that intervention takes place before a problem is serious enough to require a call to the hotline?

Disproportionality Subcommittee

Key points of discussion for this subcommittee included the following:

- The Commission has a small subgroup that has begun to explore overrepresentation of fatalities among minority children and strategies specific to eliminating CAN fatalities among minority children. That group has begun to speak to people across the country about this issue, but it has not been established whether the group focused on disproportionality is an official Commission subcommittee.
- The issue of disproportionality has been raised because fatalities affect African-American and AI/AN children at rates as much as three times higher than white children.
- One potential role of the Subcommittee could be coming up with questions that each of the other subcommittees should be considering in their own work.
- A primary question for the Subcommittee must be: Are there any communities where they have been successful in eliminating CAN fatalities among minorities? Can the Commission identify some best practices to reduce disproportionality?
- It is important to note that reducing disproportionality in foster care and protecting minority children from CAN fatalities are two different goals. Also, reducing the number of kids in foster care overall doesn't necessarily reduce disproportionality.
- The Subcommittee (and then Commission) needs to play an education role on this issue, to draw attention to the fact that minority children are overrepresented among children who die from CAN fatalities.
- For Indian Country, the issue is not clear. There are many questions about who is deciding what counts as a CAN fatality, no one really knows how many AI/AN children are dying. The issue of data for Indian Country is a complicated and critically important one. Are records kept, how, and for how long? There is only one child death review committee in Indian Country, and it's just getting started in the Navajo Nation.
- It is known that AI/AN kids are dying disproportionately from suicide.
- Commission members agreed that it is important to the CECANF mission that Disproportionality be recognized as an official subcommittee.
- Questions for the Subcommittee to address will include the following:
 - Is there an increased risk of victimization for minority children?
 - If so, why do CAN fatalities impact minority children disproportionately?
 - Are there initiatives targeted toward certain communities, and what is known about the success of those programs?
 - *Should* systems be targeting initiatives to minority communities? What are the potential unintended consequences—will it contribute to the disproportionality of children involved with the child welfare system?

Measurement Subcommittee

The Measurement Subcommittee continues to follow up on several issues raised at earlier meetings, including the following:

- Adding recommendations to address specific concerns about counting CAN fatalities in Indian Country, including support to Tribes to build data systems and capacity
- Working with the Policy Subcommittee to understand the policy implications of the draft measurement recommendations
- Proposing a recommendation that states' submissions to NCANDS be mandated, rather than voluntary

Military Subcommittee

Key points of discussion for this subcommittee included the following:

- There continues to be a lack of understanding about the true rate of CAN fatalities among children of military personnel. In part this is a factor of confidentiality/data-sharing concerns between military family advocacy programs and local CPS agencies.
- Currently, it appears as if the child abuse and neglect rates are lower among the military than in the civilian community, but the data may not be accurate. Nor are there accurate data to determine relative CAN fatality rates.
- The Military Subcommittee is working toward inviting family advocacy program representatives to come up with recommendations CECANF could make that would strengthen the military's ability to know which families are at risk, obtain accurate data, and more effectively support military families.
- The Military Subcommittee will talk with the Disproportionality Subcommittee about any potential overlap, due to the overrepresentation of people of color among non-officer military personnel.
- There is tremendous concern about what is not known with this population and the potential for children to slip through the cracks due to the lack of communication. The question was raised whether the Commission should ask the government to identify and link some of the relevant data and provide it to CECANF, for at least a crude comparison between military and civilian populations.
- Commissioner Rubin provided an overview of two military studies currently under way at the PolicyLab with the Army:
 - One looked across deployment cycles to identify periods of particularly high risk for children. It found that, with the majority of soldiers who deployed once, during the first six months after a soldier's return home, there were significant elevations of serious physical abuse, including severe, nonfatal injuries. This is a period of time that was specifically addressed by programs in El Paso County, Colorado, but programs such as these are currently "commander specific." Is there a way to make them more uniform across the military?
 - The second study looked at medical diagnoses of child abuse in the TRICARE database among children 0-2 years of age. Only 1 in 5 medically diagnosed child abuse cases were ever detected in a report to a family advocacy program. (This is consistent with findings from earlier National Incidence Studies, which show that among the general population, less than one third of incidents of child abuse or neglect are reported to CPS.)
- The Subcommittee anticipates working in partnership with the military, rather than dictating recommendations to them. Family advocacy program staff will work with military leadership to identify appropriate recommendations around ways to strengthen the military's ability to

support its families.

Closing

Before closing the meeting, the Commissioners returned to two issues raised earlier:

- There is a need to explore the options for more flexible funding to support child welfare programs and Commission recommendations.
 - The Public Health Subcommittee suggests that the Commission will need to look at funding options beyond title IV-E. It will be helpful for the Commission to have information about what funding streams might fall within a proposed plan, what flexibility currently exists within those funding streams, what are the mission and eligibility requirements for these streams, and where savings might be realized. Staff will look into providing this for the Commissioners.
 - It will be helpful for future panels to be prepared to address the ways in which current funding streams help and/or hinder their work in developing a coordinated community response to CAN fatalities.
 - The CPS Subcommittee has been looking at state budgets and CPS spending as a proportion of state spending, relative to outcomes.
 - There was some discussion about whether the Commission will include recommendations that would require new funding, in addition to changes to requirements and eligibility for existing funding. This question remains open for consideration, until more is learned in the remaining hearings about current spending and the effectiveness of interventions.
- The Policy Subcommittee was asked to review previously released national-level reports by private organizations, in addition to those by prior federal commissions, and bring recommendations forward for consideration by the full Commission. The CPS Subcommittee will review prior state and local reports.

The meeting adjourned at 12:00 p.m.

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



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

6/5/15

Date