



COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

**Not One More Death From Child Abuse and Neglect:
A 21st Century Strategy for Protecting Our Kids**

CECANF FINAL REPORT: Updated Outline 10.30.2015

FRONT MATTER

- A brief description of the Commission, its charge, and a list of Commissioners' names
- Letter from Chairman Sanders
- Executive Summary (this should stand alone but will be part of the final print document)
- Table of Contents

INTRODUCTION

CHAPTER 1: CPS AGENCIES IN CRISIS

SECTION I: CORE COMPONENTS OF THE NATIONAL STRATEGY

- **CHAPTER 2: COLLECTIVE RESPONSIBILITY FOR SAFETY**
[Proposed story: Wichita, KS]
 - Recommendations:
 - Recommendation 2.1: Require the U. S. Department of Health and Human Services (HHS) to lead the development and oversight of a comprehensive national plan that articulates federal goals and specific roles for all federal agencies involved in preventing child abuse and neglect fatalities.
 - Recommendation 2.2: Prevent child abuse and neglect fatalities through greater alignment of federal resources with the goals of child safety.
 - Recommendation 2.3: Through legislation, Congress should direct states to develop and implement a comprehensive state plan to prevent child maltreatment fatalities.

- Recommendation 2.4: The governor and legislature of each state should convene a public-private stakeholder summit to raise awareness of child abuse and neglect fatalities and identify a strategy for supporting the state plan to eliminate child abuse and neglect fatalities.
 - Recommendation 2.5: The governor should designate an interagency state lead for a statewide collective impact initiative to prevent child abuse and neglect fatalities.
 - Recommendation 2.6: States should be incubators of innovation in addressing new modalities for fatality prevention. This should be supported through federal innovation dollars and collaboration with public-private partners.

- CHAPTER 3: LEADERSHIP AND ACCOUNTABILITY
 - [Proposed story: Salt River Pima-Maricopa Indian Community]
 - Recommendations:
 - Recommendation 3.1: Elevate the issue of child abuse and neglect fatalities within the federal government.
 - Recommendation 3.2: Under the Government Performance and Results Act (GPRA), the executive branch should establish performance goals specific to the reduction of child abuse and neglect fatalities.
 - Recommendation 3.3: The Children’s Bureau should issue regulations regarding disclosure following a fatality.
 - Recommendation 3.4: The Children’s Bureau should add measures specific to child abuse and neglect fatalities to its Child and Family Services Reviews (CFSRs).
 - Recommendation 3.5: Each governor should create a permanent state task force for reducing child abuse and neglect fatalities.

- CHAPTER 4: DECISIONS GROUNDED IN STRONGER DATA
 - [Proposed story: Hillsborough County, FL]
 - Recommendations:
 - Recommendation 4.1: Develop a national child abuse and neglect fatalities data tracking system.
 - Recommendation 4.2: Develop a standardized operational definition and multidisciplinary process for identifying child abuse and neglect fatalities.
 - Recommendation 4.3: Collect comprehensive data about the circumstances that precede the fatality in addition to data about the circumstances of the fatality itself.
 - Recommendation 4.4: Group near fatalities with fatalities for the purposes of counting, classification, and development of prevention programs.

SECTION II: APPLYING WHAT WE KNOW

When the three core components come together, communities can more effectively apply what we know to save lives.

- **CHAPTER 5: IMPLEMENT STRONGER CHILD PROTECTION METHODS**
 - **Summary:** This chapter outlines the vision for a transformed child protection system, articulating critical strategies both within CPS and across the web of stakeholders beyond CPS, to more comprehensively and proactively prevent child abuse and neglect fatalities. It recommends four fundamental policy shifts and provides a list of recommended strategies to support each of these shifts.
 - **Recommendations:**
 - **Recommendation 5.1: Shift child protection policy from an incident-based model toward a safety-based model in which decisions about interventions to protect very young children (ages 0-3) are based on safety concerns and do not necessarily require an incident of abuse or neglect.** Strategies:
 - Congress should authorize funding to support a multidisciplinary initial CPS response to child abuse and neglect reports in which a nurse, substance abuse specialist, or mental health professional accompanies the CPS responder as may be indicated by the content of the report to the CPS agency.
 - Congress should authorize demonstration projects involving multidisciplinary review of cases in which serious harm or endangerment has occurred.
 - Apply stronger research methods to the development of safety assessment criteria and adapt safety assessment methods to the changing context of CPS agency involvement over the life of the case.
 - Develop standardized ways to measure severity of harm, severity of risk, and severity of maltreatment to an individual child and to the family/other children in the home. Develop tools to support decision-making at all touch points of the CPS system.
 - Consider threat of harm as a basis for CPS agency response—even when exposure to the threat may not yet have resulted in an incident of maltreatment—and as a basis for other key service providers to consider child endangerment.
 - Expand the use of safety assessment protocols by law enforcement, adult mental health providers, substance abuse providers, pediatricians, and other social service professionals providing services to families with children under the age of 3.
 - Develop and implement secondary review protocols for children judged not to be in present danger to better recognize families in which threats of harm still may be present or protective capacities may be weak. These conditions may not be presently endangering the child but may constitute a high probability that serious harm will occur absent an effective intervention.

- Implement electronic cross-reporting with law enforcement similar to the Electronic Suspected Child Abuse Reporting System (ESCARS) in Los Angeles.
 - Implement real-time case reviews of high risk in-home cases, with a specific focus on aspects of case practice that can increase the risk of a fatality, such as Rapid Safety Feedback in Florida.
 - Expand the practice of baby courts.

- **Recommendation 5.2: As a matter of national and state policy, improve surveillance, screening, and the provision of prevention and early intervention services to children and families most at risk. Strategies:**
 - All referrals to child protective services agencies involving children ages 0-3 should result in a safety assessment within 24 hours, regardless of whether there is a specific allegation of maltreatment.
 - All referrals to child protection agencies for physical abuse involving children ages 0-3 should receive a medical evaluation that includes an examination of any prior history of suspicious injuries.
 - Investigations and assessments involving children ages 0-3 should include multidisciplinary staffing.
 - Expedited access to home visiting services should be available for all families with children ages 0-3 based on a referral from the CPS agency or a pediatrician.
 - Expand birth match programs as currently operated in Michigan and other states.
 - Develop policies that address sources of stress in parents and caregivers, and provide tools and training to parents for dealing with toxic stress to help diffuse potential child maltreatment before it happens. Integrate strategies that build child and adult caregiving capacities to succeed within complementary policies that collectively lower the burden of stress on families.
 - Ensure that children and families at risk have priority access to effective mission-critical services, especially as they relate to adult mental health, substance abuse, insufficient caregiver protective capacities, and domestic and interpersonal violence.
 - Prioritize prevention and support services to prevent and address abuse and neglect by young parents in the child welfare and juvenile justice systems. These young parents have many risk factors, and government systems are responsible for them and already have access to them.
 - Test and develop the ability of home visiting to reduce child abuse and neglect fatalities. Utilize the research infrastructure through the national Home Visiting Research Network to support this effort.
 - Expand Medicaid coverage for home visiting services.

- Expand the screening of caregivers for elevated risk factors (e.g., Oregon's well-being screen or Montefiore's Adverse Childhood Experiences [ACEs] screen), and provide early connections to services.
 - Develop evidence-based screening tools for ACEs.
 - Support postpartum depression screening for the prevention of child maltreatment.
 - Ensure that all children eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit within Medicaid are receiving the necessary pediatric services.
 - Develop new pediatric quality measures for family risk assessment, failure to thrive, and early childhood injuries.
 - Develop clinical guidelines for specific injury situations (e.g., infant with a bruise and a fracture, child with a burn) in order to decrease missed cases of abuse in which the child goes on to have more severe injuries.
 - Fund and support child abuse workforce development.
 - Ensure that health information exchanges facilitate access to injury and health service histories of children at the point of care, especially for children presenting with injuries in the emergency department.
- **Recommendation 5.3: Establish national standards for supervisory and case management workload commensurate with the child safety requirements.**
Strategies:
 - The Administration for Children and Families (ACF) and states should work together to identify standards for case supervisory and management oversight of practices critical to child safety.
 - Caseloads and workloads should be designed to support the level of contact with families necessary to assess the current status of a child's safety and a caregiver's progress, with intensive contacts in instances in which children remain at home or have been reunited with parents.
 - **Recommendation 5.4: Develop supportive payment strategies that recognize activities necessary to protect children from a child abuse or neglect fatality.** Strategies:
 - Identify new payment strategies that might reimburse family-based services (e.g., parental mental health services) in meeting the responsibilities of EPSDT for a child.
 - Capitalize on state and payer investment in primary care medical homes and health homes to increase access to trauma-informed programs (for both parents and children), home visiting services, and other family-based social services within primary care settings.
 - Expand efforts to shift reimbursement to think about both the "whole family as a system of health" and then the "health care delivery team as a whole system."

- Permit physician reimbursement under Medicaid for participation in child abuse and neglect multidisciplinary team activities.
- **CHAPTER 6: DEVELOP NEW TOOLS AND STRATEGIES TO APPLY WHAT WE KNOW**
 - **Summary:** This chapter argues that we must continue to expand what we know and grow our capacity to analyze data and employ resources based on the findings to protect vulnerable children. Recommendations present several opportunities to collect and use data in new ways to improve decision-making and better protect children.
 - **Recommendations:**
 - **Recommendation 6.1: Enhance support for sharing local data in real time to improve decision-making and protect children.** Strategies:
 - Eliminate barriers to collaboration and sharing of information across agencies (law enforcement, courts, medicine, and behavioral health) to allow effective safety investigations and assessments of children potentially at risk of harm.
 - Require cross-notification of all allegations of child abuse and neglect between law enforcement and CPS agencies.
 - **Recommendation 6.2: Support expanded efforts to share data from large, administrative data sets to better understand risk and inform practice and policy.** Strategies:
 - Develop standardized ways to measure severity of harm, severity of risk, and severity of maltreatment to an individual child and to the family and other children in the home.
 - Develop tools to support decision-making at all touch points of the CPS system.
 - Explore promising approaches for better understanding risk and targeting services and supports, such as predictive analytics and geographic information system (GIS) mapping.
 - **Recommendation 6.3: Apply principles from safety science to improve child protection.** Strategies:
 - The federal government should require state CPS agencies to have proactive safety management programs, also known as safety management systems, similar to those required in aviation and hospitals.
 - Support states in the development and implementation of systemically oriented case review, such as is being used in the United Kingdom and in Tennessee, for all fatality cases in which the child or family was previously known to the CPS agency.

- Work with the pioneers of safety science to facilitate adaptation and incorporate lessons into CPS agencies.
- **Recommendation 6.4: Establish a Center for Research on Child Abuse and Neglect Fatalities and Near Fatalities within [agency identified in Chapter 3, Recommendation 3.1].** The center would encourage public and private collaborations to fund research and an overall focus on linking research to changes in policy and practice.

SECTION III: CONSIDERATIONS FOR SPECIFIC COMMUNITIES

- **CHAPTER 7: PREVENT CHILD MALTREATMENT FATALITIES IN AMERICAN INDIAN/ALASKA NATIVE COMMUNITIES**
- **CHAPTER 8: ADDRESS DISPROPORTIONALITY**
- **CHAPTER 9: STRENGTHEN MILITARY FAMILIES**

SECTION IV: NEXT STEPS

- **CHAPTER 10: IMPLEMENTATION/NEXT STEPS**

APPENDICES

- Protect Our Kids Act (text of the law)
- Commissioner names, photos, and bios
- List of meetings and people who have presented
- List of stakeholder events (est. 4 pages)
- List of stakeholder groups that we've engaged (est. 2 page)