COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

DELIBERATION MEETING MINUTES
December 7-8, 2015

Meeting Location: Hilton Washington Dulles, 13869 Park Center Road, Herndon, VA 20171

Commissioners Present: Chairman David Sanders, Bud Cramer, Theresa Covington, Susan Dreyfus, the Hon. Patricia Martin, Michael Petit, and Dr. Cassie Statuto Bevan

Attending by Phone: Amy Ayoub, Dr. Wade Horn, Jennifer Rodriguez, and Dr. David Rubin

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 Monday, December 7, 2015, from 8:00 a.m. to 5:30 p.m., and Tuesday, December 8, 2015, from 8:00 a.m. to 12:30 p.m., at the Hilton Washington Dulles in Herndon, Virginia. The purpose of the meeting was for Commission members to discuss the recommendations to be included in the Commission's final report to the White House and to Congress, as well as other content and process matters.

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.

Monday, December 7, 2015

Chairman Sanders opened the meeting by reviewing the agenda (https://eliminatechildabusefatalities.sites.usa.gov/files/2015/11/VA_Mtg-Agenda_12.7-8.-2015.pdf) and the goals for the meeting. He stated that the development and approval of final recommendations would need to be bipartisan and would require compromise. He noted that the meeting discussion would focus on approving content and recommendations from the drafts of the report's Introduction and Chapters 1-4. The message of Chapter 1 would need to evoke the urgency of the problem.

Draft Chapter 1

Commissioners discussed a draft of Chapter 1 that included the following recommendations:

- 1.1: Anticipate harm to children who are already known to CPS agencies.

- 1.2: Make the health care system responsible for reviewing all near fatalities on an ongoing basis.
- 1.3: Focus on children at an elevated risk of fatalities.
- 1.4: Anticipate harm to children who are not known to CPS by requiring pediatric screening of risk for fatalities.
- 1.5: Starting with law enforcement and CPS, require a multidisciplinary decision-making process during investigations and case closure, including data sharing, to ensure children's safety.

The subsequent discussion among Commissioners about the draft of Chapter 1 highlighted a number of points and opinions:

- There was some concern regarding the distinction between short-term and long-term recommendations.
- Ways to emphasize the urgency should be improved, perhaps through a method similar to the one used by the Bush administration to address pandemic flu.
- The urgency expressed in Chapter 1 cannot be siloed so that it applies only to child protective services (CPS); it must include collective responsibility by many professions and groups.
- There should be some inclusion of innovation funds for states to use through their state plans as they try out new ways to prevent child abuse and neglect fatalities.
- The issue of requiring states to develop plans to address child maltreatment fatalities should be in Chapter 1.
- The issue of requiring a surge in all states should be included in Chapter 1.
- The recommendation to screen in almost all cases reported to CPS should not be limited to children under a particular age.
- The issue of requiring health care workers to be responsible for reviewing near fatalities needs to be discussed.
- There was a question about whether enough is known about the Hillsborough County (Florida) Rapid Safety Feedback method to propose it as a model. One suggestion was for the recommendation to allow states to determine how to implement increased safety methods once they receive more resources.
- Requiring pediatricians to screen infants for risk of maltreatment fatality may be impractical.
- Pediatricians should receive quality training on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and should be required to do comprehensive EPSDT screening.
- Chapter 1 should not include very specific recommendations but should focus on increasing accountability; more specific recommendations will be offered in later chapters.
- Accountability needs to be tied to something, such as licensing or accreditation, in order to make it enforceable.
- The report should include the degree to which CPS is grossly underfunded, through CAPTA and otherwise.

In discussing **Recommendation 1.4**, the Commission agreed on the following wording:

Assess the effectiveness of screening tools for psychosocial risk to improve those tools; increase accountability of health care professionals, EPSDT providers, and early childhood/intervention providers to assess and intervene for psychosocial risk; and to address shortcomings in current policy.

The Commissioners then discussed whether every call to CPS should be investigated in person. Some Commissioners suggested that every call involving children under a certain age should be investigated or every call made by a pediatrician or teacher should be investigated. Others suggested that responding to every call with an in-person investigation would be potentially unfair to parents because the CPS system is incentivized to remove children. Others pointed out that children under 5 years are most at risk, and their safety should be prioritized. It was also suggested that households that have had a certain number of past reports should be investigated.

Chairman Sanders offered the following wording for Recommendation 1.3: Every child, where there's an allegation of abuse or neglect, must be investigated, period. For young children, if somebody expresses concern through a call to the child protection hotline, even if they do not meet the state's definition of abuse and neglect, they should be seen because it appears from the research that they are at higher risk because of their age.

However, the subsequent discussion pointed out that this wording already exists in CAPTA. A suggestion was made to restate the CAPTA language and prioritize certain populations. Other Commissioners suggested that CAPTA may not be the vehicle for this recommendation. Rather, title IV-B might be better. Audience member Christine Calpin, former Associate Commissioner of the Children's Bureau, also provided some input when asked. The discussion led to the following wording for **Recommendation 1.3:**

Amend title IV-B, section 432a(10) to read, "states will develop a protocol to screen and investigate all hotline calls for children under age 5 and children for whom prior CPS reports were made for them or for their family members."

When asked by Chairman Sanders, Commissioners raised no objection to this language for Recommendation 1.3.

The Commission then moved on to discuss the proposal to include a "surge," which was initially defined as looking again at children with substantiated reports of abuse or neglect who remain in their homes, usually with family services. The argument made was that these children are at increased risk for fatality, especially if they are younger and if they or their family members meet other specific criteria. Commissioners debated the proposed surge, making the following points (not necessarily with consensus):

- The surge is second-guessing the judgments of therapists, social workers, and judges who deemed the children to be adequately safe in their homes.
- Arguments were presented both in favor of and against the use of Hillsborough County as a model for the surge.
- Testing the Hillsborough model through demonstration sites around the country for jurisdictions that would volunteer might be more feasible than requiring it for all jurisdictions.
- It makes more sense to test the Hillsborough model through demonstration sites because Hillsborough doesn't yet have enough results.

- There should be a distinction between children known and not known to CPS.
- There are various ways to fund the demonstration sites, including a title IV-E match, open-ended entitlement money, Children's Bureau or Department of Justice monies, or other funds.
- The surge recommendation must include the fact that the results will build knowledge and a learning community in the long term.
- The Commission was reminded that Eckerd Kids, which ran the Hillsborough approach, began by organizing and funding a multidisciplinary quality and safety improvement review of all open cases. That allowed them to come up with a profile of the cases at highest risk.
- There was discussion around what organization should initiate and carry out such a project, with various opinions on whether or how the federal government should be involved and whether or how states should partner with private entities.
- Other models besides Hillsborough might be included in the report, including El Paso County, Colorado, and Omaha, Nebraska.
- There was eventual consensus that the U.S. Department of Health and Human Services (HHS) would be in charge of this type of surge project, in collaboration with states and other federal partners.

Definitions of children "at highest risk" differed among Commissioners, with some saying that this population included all children in open CPS cases, and others defining the group by age or other criteria. Part of the difficulty in coming to agreement around this term was that different jurisdictions use different language, for instance, in defining what constitutes an "open case."

Commissioners agreed to the following language for **Recommendation 1.1**: **HHS should sponsor, in collaboration with other federal partners and states, demonstration projects to conduct multidisciplinary reviews of children known to CPS and change the intervention for those children if needed to ensure safety and contribute to a national learning community.**

Chairman Sanders asked about other comments for Chapter 1. Commissioners responded with the following issues (not necessarily with consensus):

- The Commission needs to settle on an approximate number of annual fatalities. Everyone agrees that the estimate from the National Child Abuse and Neglect Data System (NCANDS) is an underestimate, but the Commission needs to decide which other number to include in the report.
- The report should include an estimate of costs and where the funding would come from to carry out the report's recommendations.
- States should be required to collect and publish comprehensive data on child deaths due to abuse and neglect.
- The Federal Interagency Workgroup on Child Abuse and Neglect (FEDIAWG) could play a bigger role in collecting national data on fatalities. It could also play a bigger role in providing leadership among federal agencies on this issue.
- Evidence-based programming for addressing child maltreatment fatalities is lacking. The report cannot just be based on recommending promising practices that have no evidence.

- The role of CAPTA must be addressed in the report, including the effectiveness (or lack thereof) of the three review panels mandated by CAPTA: foster care review, citizen review, and child death review.
- The report also needs to include recommendations around titles IV-E, IV-B, and XX.
- Various wording changes need to be made throughout Chapter 1, especially in sections that describe why the number of fatalities remains constant.
- There may be too much emphasis on services for parents and not enough emphasis on the environmental effects of poverty and stress, including stress caused by unemployment, health issues, lack of housing, and more.
- Chapter 1 as a whole should focus only on the problem of child maltreatment fatalities, and subsequent chapters should supply the recommendations for response.
- The purpose of the anecdotes needs to be understood and applied consistently.
- There should be recommendations around who determines whether a child fatality was due to abuse or neglect, and there should be a national registry of these deaths. The report needs to talk about the inconsistency from state to state in classifying child deaths as due to maltreatment or to another cause.
- There should be more text around the problem, especially describing neglect and the impact of toxic stress.
- In addition to pointing out what CPS is not doing to protect children, Chapter 1 should include language about what other professions (e.g., law enforcement, health care) should be doing to protect children.

The Commissioners also discussed the role of CPS in the 21st century child welfare system, with some calling it the anchor or the center of a bicycle wheel. Other agencies revolve around it. There was also discussion about the relative weight that the report should give to prevention and upstream services since the charge to the Commission was to address child maltreatment fatalities, not child well-being. It was suggested that the 21st century child welfare system would allow other kinds of responses to families that were not necessarily CPS responses. For instance, the responses might be from a housing agency—if that is what the family needs—or from mental health services.

This led to a discussion of accountability. If CPS is the lead organization, is it also the organization held accountable for results? Other professions should also have some accountability, but leadership and accountability are linked. The public's view of CPS also plays into this, because they view CPS as it exists today, not as what it might be in the new 21st century child welfare system. For instance, there are pregnant women with drug problems who are afraid to get prenatal care because they are worried that their infants will be taken from them at birth. This is the view that many people have of CPS.

Chairman Sanders asked Commissioner Bevan about a white paper drafted by the Policy Subcommittee, titled *A Path Forward: Policy Options for Protecting Children from Child Abuse and Neglect Fatalities* (https://eliminatechildabusefatalities.sites.usa.gov/files/2015/11/A-Path-Forward-Final-12-03-15.pdf). She noted that it includes a look at state plans, current law, and what can be done with incentives.

There was a brief discussion about the graphic in Chapter 1, specifically, the wording on the graphic. It was suggested that the line about population health be replaced with "a shared community and family responsibility to protect our children."

There was a brief discussion about teen pregnancy as a risk factor for child abuse and neglect and near fatalities.

The Monday session was adjourned at 5:17 p.m.

Tuesday, December 8, 2015

Chairman Sanders opened the Tuesday session by introducing several visitors in the audience. He then asked Commissioners for any remaining feedback on the report's introduction and Chapter 1. The following feedback was offered (not necessarily with consensus):

- The sense of crisis in the report needs to be elevated, for example, by moving the comparison of child maltreatment fatalities to the numbers of children killed by cancer and by auto accidents so that these comparisons are earlier in the text.
- There is not enough emphasis on neglect.
- It is an oversimplification to say that the problems with CPS are due to lack of funding and overwork of caseworkers.
- A strong and vital response by CPS is an integral part of the 21st century child welfare system.
- The current language describing a population health approach is not effective and needs to be rewritten so that it resonates with readers. The report should not shy away from using the term "public health."
- The report should include more recognition of the importance of families.
- There should not be a competition between strengthening families and keeping children safe; both approaches must be used and appreciated.
- The report should include the surge as a big idea, as well as adding $1 billion to CAPTA, addressing confidentiality/transparency so that states are required to share information about child abuse deaths with the public, and establishing national child welfare standards and requiring states to comply with those standards.
- The Commission should ensure that the final report gets wide distribution and the maximum amount of exposure and publicity.
- There should be a recommendation around governance such that CAPTA is under the same governance as title IV-E.

There was discussion about funding. Chairman Sanders noted that the Commission had not seen evidence that more spending results in fewer child maltreatment fatalities. He also suggested that the role of the Commission is to identify policy and then associate a funding number with the policy. The idea of spending money to reduce caseworkers' average workload to some national standard was debated. The overall discussion centered on whether the Commission could or should propose a dollar amount as a down payment for the federal government to commit to ending fatalities or, as a second option, whether the Commission should attach specific policies and the costs of those policies to the dollar amount proposal. It also was proposed that the significant "down payment" by the

government could help to fund investigations in the 40 percent of cases in which a child abuse or neglect report is made but is screened out by CPS and never investigated.

Chairman Sanders summarized the Commissioners' discussion regarding the content and structure of the report:

- Chapter 1 includes five ideas that reflect the urgency of this issue. The Policy Subcomittee's report similarly contains five "big ideas," and Commissioner Petit also presented his version of five or six priority recommendations. That is the first place where the Commission needs to achieve consensus.
- Next, there is the 21st century child protection model, which is a longer term list of steps that need to be taken. There needs to be clarification about that model.
- The remainder of the report will be easier to write once those things are decided.
- What was not included thus far is a how-to section. So part of the how-to is through CAPTA, and part of the how-to is the recommendation that the Children's Bureau be elevated to a cabinet level.

Chairman Sanders drew from the discussion to offer the following recommendation: **We've seen a lack of federal resources devoted to child protection to investigate children who are at risk for later child abuse and neglect fatality. We believe the federal government has an obligation to ensure that all children at risk of child abuse and neglect fatality are investigated. CAPTA provides X number of dollars per investigation. We believe that the federal government should increase its partnership with states in funding CPS and therefore would recommend XX amount as the down payment**.

During the discussion that followed, several points were made by Commissioners (not necessarily with consensus):

- One billion dollars would be the right amount to propose as a down payment.
- It would be best to research the costs of investigations and how much it would cost to investigate every report of possible child abuse or neglect (with no reports screened out).
- CAPTA has not kept up with costs over the years.

The Commissioners then discussed their approval process for the final report. Commissioners had different understandings of what had been approved and what had been amended; in addition, there was some confusion about the commenting process and how that would be handled. The integration of the recent Policy Subcommittee white paper also was discussed.

Commissioners then returned to the topic of CAPTA and whether a billion-dollar increase in CAPTA funding was the right amount to recommend, and, if so, what it would be used for. Some Commissioners suggested it be used just for investigations, while others argued that it could be used for much more. Unlike title IV-E, CAPTA does support preventing child fatalities. There was no consensus among Commissioners on the topic of proposing an additional billion dollars for CAPTA.

As the meeting drew to a close, Chairman Sanders summarized what the next steps would be:

- Merging the Policy Subcommittee's document with the Commission's draft report to the extent possible will provide the Commission with a handful of urgent issues that need to be addressed.

- That will include CAPTA revisions and funding issues.
- The description of the 21st century child protection system will be rewritten to reflect the Commission's discussion at this meeting.
- There also needs to be a "how-to" section, which would include the elevation of the Children's Bureau and, potentially, the merging of CAPTA with IV-E.
- The issue of confidentiality also will be discussed.

The meeting was adjourned at 11:46 a.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
3/14/2016