COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MEETING MINUTES
APRIL 28-29, 2015

Meeting Location: SpringHill Suites Memphis Downtown, 85 West Court Avenue, Memphis TN, 38103

Commissioners Present: Chairman David Sanders, Amy Ayoub, Theresa Covington, Bud Cramer, Susan Dreyfus, Dr. Wade Horn, the Hon. Patricia Martin, Michael Petit, Dr. David Rubin

Attending by Phone: Dr. Cassie Statuto Bevan, Jennifer Rodriguez

Not in Attendance: Marilyn Bruguier Zimmerman

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 (CECANF) held a meeting that was open to the public on Tuesday, April 28, 2015, from 8:00 a.m. to 5:30 p.m., and Wednesday, April 29, 2015, from 8:00 a.m. to 1:00 p.m., at the SpringHill Suites Memphis Downtown. The purpose of this meeting was to explore key research, policy, and practices in Tennessee related to addressing and preventing child abuse and neglect fatalities. Speakers addressed the role of child advocacy centers and methods of developing and implementing a safety-based culture in challenging environments. Commission members then continued to discuss the work plans of the Commission subcommittees, the information that they have obtained to date, and emerging high-level recommendations.

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.

TUESDAY, APRIL 28, 2015

Introductions and Remarks: ***Commission Chairman David Sanders***

The chairman introduced the Commission and asked the Commissioners to introduce themselves. He set the guidelines for the meeting.

Opening Remarks by Tennessee Leadership: ***James Henry, Commissioner, Tennessee Department of Children's Services***

Commissioner Jim Henry gave an overview of the Tennessee child welfare system, including major changes in the last few years. Prior to his tenure, the system had experienced funding cuts, and caseloads had grown; negative media attention also grew. When Henry came to the Department of Children's Services (DCS), he set three goals:

- Keep children safe, the number one priority.

- Get children healthy. Good health is connected to well-being.
- Get kids back on track in school.

A deputy commissioner was assigned to be in charge of each of these goals.

Other key factors about the system include a focus on the following:

- Good press relations. The previous commissioner wanted to charge the press for the cost of getting information, but Henry wanted a more open system. DCS put fatality information on its website.
- Permanency, which is important for children's health and well-being. The agency communicates with judges across the state to ensure permanency.
- Open discussion with advocates in an initiative called Philosophy Wars.
- Accreditation. The state's regional services and youth development centers are now accredited.
- Support for employees, including tablets for staff to use in the field and while waiting for court hearings.
- A positive relationship with the legislature, ensuring elected officials know and understand what the department is trying to do.
- Longevity and an acknowledgment that system change takes time and that it requires creation of a safety culture that spans administrations and commissioners.

Commissioner Discussion

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

- Tennessee's IV-E waiver focuses on eight Appalachian counties with a goal of reducing the number of children in custody.
- There is a discrepancy among different data sources about the number of children who died from abuse or neglect in 2013.
- The state has a safe sleep campaign, but co-sleeping deaths have not decreased.
- Commissioner Henry is more concerned that people do not know what the department does than about hiding information. Transparency is important.

The Potential for the Children's Advocacy Centers' (CACs') Multidisciplinary Team (MDT) Process to Prevent Child Abuse and Neglect Fatalities in Families Known to the Child Protective Services System: Panel Presentation

Teresa Huizar, Executive Director, National Children's Alliance

Huizar provided an overview of the work of CACs nationally:

- There are nearly 800 CACs in all 50 states, although they do not currently reach all rural areas. In 2014, these centers served 315,000 children.
- CACs offer a coordinated MDT response to child abuse that covers investigation, prosecution, and treatment. The response includes child protective services (CPS), law enforcement, prosecution, victim advocacy, medical needs, mental health needs, and more.

- Services are culturally competent and tailored to the individual child.
- Services, including specialized medical evaluation and treatment, are provided without regard to the family's ability to pay.
- Case planning is continuous.
- Partner agencies have written protocols.
- Cases are referred by CPS and law enforcement; sexual abuse is the primary referral reason (60 percent to 70 percent, although this percentage is decreasing as more CACs move toward serving other forms of child maltreatment).
- The CAC model is proven and effective: CACs achieve shortened length of time to disposition of a case, higher levels of service provision for medical evaluation, increased access to mental health treatment, and an average savings of $1,000 per case.
- Leaders are confident that the CAC model can be effectively applied to neglect and other forms of physical abuse.

Huizar's primary recommendation was for federal regulations or statutes to allow CACs to share information across state lines. Currently, law enforcement and CPS can share data, but CACs, which have a large repository of data, cannot share it across state lines. This recommendation would not be costly. She also recommended funding for research to both (1) better understand child abuse and neglect fatalities (perhaps by pooling research funding across agencies such as the National Institute of Justice, Centers for Disease Control and Prevention [CDC], and others) and (2) adequately support the expansion of CAC services.

Chris Newlin, Executive Director, National Children's Advocacy Center

Chris Newlin discussed the origins and emerging practice of CACs and other MDTs. The first CAC was established in Huntsville, Alabama, in 1985. Within the CAC model, there are different evidence-based practices. Development of CACs was based on three principles:

- Sexual abuse of children is a serious issue and must be addressed.
- The system should help children, not further traumatize them.
- All agencies involved in the investigation and intervention of a child's case must work together. No one agency or individual can address the needs of abused children. In some cases, this collaboration has led to co-location of agencies within the same building.

Newlin presented the following points about CACs in general and the National Children's Advocacy Center in particular:

- The national center has trained more than 80,000 professionals in the United States and internationally.
- To connect practice to research, the Center hosts a digital, fully searchable child abuse library available to all CACs and MDTs.
- Many children seen in CACs have experienced multiple victimizations. CACs are increasingly aware of the need to treat children who have been physically abused or are witnesses to domestic violence or exposed to drugs. Newlin noted that a number of CACs have child abuse prevention programs.
- CACs are not just about filing criminal charges. They are about supporting the child first. Far more cases are reviewed by the MDTs than are later prosecuted.

Newlin made several recommendations to the Commission, noting the potential of a modified CAC/MDT model to help prevent fatalities. Partners could include 911 call centers, domestic violence shelters, animal abuse services, CPS (intake records and screened-out cases), hospital emergency rooms, etc. because all of these groups collect information that could indicate highly vulnerable environments for a child.

Commissioner Discussion

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

- Commercial sexual exploitation of children is an increasing concern. A national survey of CACs indicated that many of these cases are handled by the FBI or U.S. Department of Homeland Security. But there are some model CAC programs that are using a modified MDT to support these children. The survey also showed that CACs want more specialized training in this area.
- Federal seed money was key to development of the CAC model, but federal funds are limited and do not go far nationally. CACs must leverage private dollars and state and local government funding. They also get some funding from the federal Victims of Crime Act. Newlin described a braided approach to funding that includes federal, state, and local government funding as well as fundraisers, grants, and foundations. Some services are billable to Medicaid, but the cost to the average CAC of administering this process is so onerous that many prefer to raise the money privately.
- Could a version of the CAC model be the future of CPS?
- To look at the potential impact of CACs on child maltreatment fatalities, focus would have to be placed on the centers that provide services for all forms of child maltreatment, including neglect. It would be difficult to identify a control group of CACs for comparison, because they are so diverse.

The National and Tennessee's Response to Children With Drug Exposure

Chairman Sanders noted that substance-exposed infants have been of particular interest to the Commission, and this concern was the catalyst for inviting a panel of six presenters to discuss the scope of the problem and identification of possible strategies and solutions.

Dr. Nancy Young, Director, Children and Family Futures

Dr. Young led off the panel by presenting statistics on the national scope of the problem of parental drug use and its impact on children, and she discussed research on ways to address the issue. Citing statistics from the National Survey on Drug Use and Health, she testified that 11 percent of children live with a parent battling alcoholism or illicit drug abuse. Effectively responding to this challenge is made more difficult due to the following:

- Absence of solid collaborative practice
- A dearth of scientific studies on the prevalence of substance use in the child welfare population within the last decade
- Insufficient National Child Abuse and Neglect Data System (NCANDS) data, including data that link maltreatment to parental substance use

Dr. Young provided information on other national data and responses:

- The Adoption and Foster Care Analysis and Reporting System (AFCARS) shows a steady increase over the past 15 years in children removed from their homes because of parental alcohol or drug use, reaching about 31 percent in 2013.
- Examination of the reasons for terminations of parental rights reveals a similar upward trend, with some 44,000 children in 2013 having a birth parent whose rights were terminated, in whole or in part, due to substance use.
- The Health Resources and Services Administration (HRSA) has issued guidelines about the uniform screenings that should occur during pregnancy and at birth, but screening for prenatal substance exposure is not included. An estimated 500,000 babies per year are born with prenatal substance exposure.

Dr. Young spoke about the Regional Partnership Grants (RPGs) created by Congress in 2007 as part of the reauthorization of Promoting Safe and Stable Families. Congress provided $145 million over five years to identify what works in families affected by parental substance use. There were three goals:

- Improve the safety, permanency, and well-being of children affected by substance abuse in child welfare.
- Address common systemic and practice challenges.
- Establish or enhance a collaborative infrastructure to build the region's capacity.

RPG strategies included providing parents timely access to substance abuse treatment and recovery management services and the use of parenting programs adapted to parents in early recovery stages. The families participating in the RPG programs did better than comparison families in terms of recovery, children remaining at home, reunification rates, and decreased recidivism.

Dr. Young then discussed infant rollover and co-sleeping deaths. These cases are usually considered accidental, with little attention paid to the risk of parental substance use.

Dr. Young advocated for effective implementation of the Child Abuse Prevention and Treatment Act (CAPTA) provision related to Plans of Safe Care. This CAPTA provision is largely ignored, and it is difficult to identify the accountable agency or individual in any state. Also, there is insufficient guidance and monitoring by the federal government, including about how to connect the Plans of Safe Care to services provided through other federally funded programs. Dr. Young offered the following recommendations to the Commission, which could facilitate greater reliance on and accountability related to Plans of Safe Care:

- Require NCANDS and AFCARS to include parental substance use data.
- Screen all pregnant women for substance use with a validated screening tool.
- Leverage Medicaid and private health insurance to provide appropriate levels of substance use treatment and lengths of stay for all pregnant and postpartum women.
- Involve multidisciplinary teams in Plans of Safe Care prior to births.
- Designate a state office responsible for implementing and monitoring Plans of Safe Care.
- Ensure priority access to home visiting services and eligibility for early intervention services for parents with substance use problems.
- Require state child death reports to specifically assess the role of substance abuse at the time of a child fatality.

The remainder of the panel presentation focused on parental substance abuse among parents in Tennessee and the impact on children and on children's fatalities.

Dr. Scott Modell, Deputy Commissioner, Office of Child Safety, DCF

Dr. Modell highlighted some key Tennessee data:

- In calendar year 2014, the state received 140,648 calls to its child abuse reporting hotline, with another 10,000 referrals coming via email or regular mail, for a total of about 150,000 referrals, which led to 68,000 investigations.
- Between 2010 and 2014, drug-exposed children represented about 280,000 allegations, with 45 percent involving a child under the age of 5.
- Since 2010, TN has seen an approximate 20-percent increase in drug-exposed children allegations.
- In 2013, 871 children died in Tennessee, including 13 in the custody of the state. None of the children in state custody died of substantiated child abuse or neglect, but there were 46 cases of substantiated abuse or neglect among the other child deaths. Of the 42 (of the 46 children) born in Tennessee, 9 percent had been born with a diagnosis of neonatal abstinence syndrome (NAS).
- The state has seen a statistically significant reduction of 10 percent in sleep-related infant deaths.

Dr. Modell noted that Tennessee practices 100-percent redundancy on every call that is screened out. That is, if a case manager screens out a call, then a supervisor reviews the screen out; if the supervisor screens out the call, then another supervisor also reviews it.

Carla Aaron, Executive Director, Office of Child Safety, DCS

Carla Aaron provided some historical perspective about drug-exposed children, with a focus on the impact of methamphetamine and prescription drug abuse, both of which have shown dramatic increases. She traced the role of MDTs in Tennessee, which function as child protective investigative teams and have improved the partnerships between child protection, law enforcement, and district attorneys. Tennessee has implemented the following procedures to address the risk to children of parents with substance abuse problems:

- Face-to-face responses with children under the age of 2 are required within 24 hours of a report.
- Cases involving children under the age of 2 with a report related to drug exposure are sent through the investigative route versus a differential response route. This increases the likelihood the investigation will be done in partnership with law enforcement.
- In cases involving neonatal exposure to substances, interventions occur with infants in the hospital setting before the infant and mother are released. This includes working with the mother when the infant remains hospitalized to connect the mother to community-based resources.
- Timely reviews of training and policies are conducted to adjust to what CPS workers are encountering in the community.

Although DCS is intentional about addressing the risks to young children, the state has tried to ensure the safety of older children as well.

Amy Coble, State Director of Investigations, Office of Child Safety, DCS

Amy Coble provided insight into some of Tennessee's newer programs, including the following:

- Drug-exposed infant teams, which are still in the pilot stage
- Hospital liaisons, to better address the needs of children affected by NAS

The hospital liaison has enhanced communication among hospitals, CPS social workers, and child abuse physicians. The engagement of diverse disciplines and information sharing has provided more opportunities to respond to substance-exposed infants outside a formal investigation track.

Dr. Michael Warren, Assistant Commissioner, Division of Family Health and Wellness, Tennessee Department of Health

Dr. Warren highlighted Tennessee's public health response to NAS, presenting the following data:

- Among women of child-bearing age eligible for Medicaid in Tennessee, 14 percent have had more than one paid claim for more than 30 days of an opioid medication, whereas only 15 percent have had an identifiable claim for a contraception.
- Among pregnant women on Medicaid in the state, 28 percent filled at least one prescription for an opioid medication during pregnancy.
- On average, 16 percent of all pregnant women smoke in Tennessee, but there are some areas of the state where that percentage is as high as 45 percent.
- In Tennessee, 6.5 percent of pregnant women reported drinking alcohol in the last three months of pregnancy.
- NAS occurs in about 1.5 percent of all births in Tennessee, with the majority of the births being covered by Medicaid. The average first year of life for each of these infants costs $44,000, while a healthy infant costs about $4,000. Although these infants represent only 2.5 percent of all Medicaid births, they account for 14 percent of all infant Medicaid expenditures.

There are two ways to prevent NAS:

- Prevent opioid misuse or abuse among women of child-bearing age.
- Prevent unintended pregnancy among women at risk of opioid misuse or abuse.

Tennessee convened a subcabinet group in 2012 to identify solutions to the NAS epidemic. Representatives from child-serving organizations, Medicaid, and human services identified a number of needs, including a reliable measure of the extent of NAS. The Commissioner of Health made NAS a reportable event beginning in 2013. The reporting was for public health surveillance only, and no identifying information was collected. The weekly surveillance data are posted publicly, along with analysis that highlights prevention opportunities. This enhanced surveillance and time-sensitive data show the following:

- There were 936 NAS cases in 2013 and 1,018 in 2014.
- In 2014, 69 percent of the mothers were taking at least one drug prescribed to them by a health care provider, with 80 percent taking a replacement therapy.
- Between 2013 and 2014, there was a statistically significant decline in infants exposed to illicit and diverted drugs and a statistically significant increase in infants exposed to prescription drugs.

Tennessee has implemented additional strategies such as the following:

- A prescription drug monitoring program provides a database for health care providers to check before writing a prescription for an opioid or benzodiazepine.
- The state petitioned the Food and Drug Administration (FDA) for a box warning that appears on extended-release opioid analgesics.
- Health officials are partnering with methadone clinics on family planning services.
- The state has implemented a universal outreach program as part of its evidence-based home visiting program so that every mother of a new baby receives a packet of information on safe sleep and tobacco exposure.
- Birth certificates are analyzed for a number of other risk factors, and those infants at medium or high risk for an infant death receive additional outreach.

Amy Weirich, District Attorney, 30th Judicial District of Tennessee, and Michael Dunavent, District Attorney, 25th Judicial District of Tennessee

The district attorneys provided the Commissioners with perspective about the approach of law enforcement when responding to infants born addicted to illegal drugs.

- In recent years, Tennessee enacted a statute, which will expire in 2016, that permits prosecution of a mother for assault when her infant is born testing positive for illegal drugs. The statute provides a tool to work with mothers, often through drug courts, to connect the mothers to treatment services. If the mothers succeed at treatment, the charges are dismissed and expunged from their record, which is a huge incentive.
- Dunavent spoke about the added challenges faced by rural communities with less availability of drug courts and a significant problem with the manufacture of methamphetamine. Tennessee developed a drug-endangered child protocol so that there is attention to investigations, as well as a way to connect children to services.

Commissioner Discussion

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

- Because Medicaid pays for approximately half of all births in the United States, practices infused into Medicaid (e.g., screening of pregnant women) could be a lever for CAPTA's requirement for Plans of Safe Care. Another lever is the Parity Act (Mental Health Parity and Addiction Equity Act of 2008), requiring that mental health and substance abuse services be made as available as medical health care.
- There are opportunities to have CACs be more proactive than reactive; co-location of various disciplines would be one way to do that.
- The significant decline (21 percent) Tennessee experienced between 2008 and 2013 in the overall mortality rate for children, as well as the reduction of racial disparity in deaths, is linked, in large measure, to strategies implemented to reduce infant mortality.
- Although there are regulations and barriers to data sharing across systems, Commissioners were assured that there is an exception that permits sharing information about substance use as long as it does not relate to a person's current history of or participation with treatment.
- There is a need for coordinated care and systems of care around infants born with NAS and their families.

Enabling, Enacting, and Elaborating a Safety Culture: Tennessee's Journey: Panel Presentation

Three panelists presented the theory and practice of applying a safety science approach to child welfare. "Safety science" is a term that represents a number of disciplines (including psychology, business, and engineering) coming together to improve safety.

Dr. Scott Modell, Deputy Commissioner, Office of Child Safety, DCS

Dr. Modell discussed the culture changes required to improve safety, making the following points:

- Culture change is a fairly slow process. In this process, organizations go through predictable stages: enabling, enacting, and elaborating.
- It is not unusual to see these changes arise from a crisis. For instance, Tennessee had begun the process of exploring safety culture in late 2012, but soon after they experienced a series of significant safety events in youth development centers. These crises tested the state's resolve but ultimately convinced staff that this is the right approach.
- There is a pattern of crises in child welfare across the United States: The cycle of budget reductions, followed by high-profile media coverage of child deaths, outrage, and money added back to the system has been repeated across multiple states.
- Creating a safety culture in child welfare agencies is the "next frontier" and offers a way out of this cycle.

Tennessee borrows from safety practices in other fields, including aviation, nuclear power, the military, and more. A comparison of expert findings about disasters in aviation and child welfare reveals key differences in how failures are reviewed:

- Child welfare reviews tend to focus more on blame and backward-looking accountability.
- Responses to aviation disasters focus on what can be changed within the system to prevent similar incidents in the future.

Noel Hengelbrok, Director of Safety Analysis, Office of Child Health, DCS

The way an agency learns and improves is dependent on the agency's safety culture. Too often in child welfare, blame is aimed both at the frontline worker and the executive staff. Organizations with a strong safety culture use accountability in a forward-looking way. They see frontline staff as being the source of success rather than failure and bring them in to help rebuild after a crisis.

Tennessee has done the following:

- **Enhance surveillance** through child death reviews and a new reporting system that allows social workers to inform leadership without penalty about the constraints they face and how those constraints may impact child safety
- **Improve communication** both within the agency and across agencies and departments

Tennessee's approach to child death review relies on strong safety science principles.

- There are four safety science experts involved with implementation across the state who conduct debriefings from the death reviews with frontline staff.

- The child death review tool allows the death review teams to see concerns throughout the system, from the frontline staff up to legislative and regulatory issues. It also aids analysis by turning qualitative data into quantitative data.
- Findings are presented to a safety action group that is empowered to create and enforce change.

Dr. Michael Cull, Deputy Commissioner, Office of Child Health, DCS

Dr. Cull described a safety culture survey Tennessee conducted in 2013 to establish a common language and common understanding of the meaning of "safety."

- The survey resulted in a very positive media experience; the state was seen as "giving voice" to their front line.
- The survey used validated scales from other industries, adapted to child welfare. It measured staff perceptions of things like safety climate, relationships with supervisors, and psychological safety, among others.
- Staffed rated poorly in the area of "stress recognition," that is, the ability to recognize the effects of stress and fatigue on decision-making. As a result, the agency is focusing more efforts on building a resilient workforce. They are realizing they need to engineer more safeguards into the system rather than waiting for staff to recognize their own stress and burnout.

Dr. Cull suggested that child welfare workers need to be treated the way we treat truck drivers, pilots, doctors, and others who make high-profile, high-stakes decisions. The system needs to recognize, anticipate, and prevent the effects of fatigue and stress on those decisions. Some of the tools Tennessee is using include forming smaller teams, providing better tools, and offering more surveillance and training.

Commissioner Discussion

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

- Some recommendations for addressing the workforce issue include focusing on better science and creating systems that support safety, rather than relying on individual judgment. Child welfare could look to fields in which federal oversight and professional training and licensure have helped to advance safety, such as aviation and health care.
- National research on patient-centered safety outcomes has advanced health care in the last five years. Child welfare needs a similar research vehicle.
- Tennessee is making an effort to raise caseworker salaries. But money is third or fourth on the list of importance, behind "feeling supported" and "making a difference."
- Tennessee has a new confidential reporting law (Public Chapter 21) requiring that the name of the person who reports a safety issue is confidential, but the information reported is not. There is precedent for this approach in child abuse reporting laws.

Commission Deliberations

For the remainder of the first day of the meeting, Commissioners discussed a draft report outline and recommendations by the Public Health Subcommittee.

Discussion of Report Outline

The Commission plans to vote on a full report, not recommendation by recommendation. Chairman Sanders presented a draft outline that incorporated many of the recommendations received thus far from subcommittees. It was presented for discussion about the direction of the report and to determine whether there were pieces that the staff could begin working on.

The Chairman provided some context to his thinking on the outline and possible chapters within the final report, making the following points:

- Tell the story about the children and the lessons learned as the Commission connected with communities.
- Stay focused on the Policy Subcommittee recommendations on effectiveness, accountability, and efficiency.
- Prevention requires strategies beyond the formal child welfare system.
- Identify what works and what doesn't work.
- Draw on lessons and strategies from other industries (e.g., health care, airlines), particularly as to how they operate with a safety culture.
- Address the measurement and counting issues.
- Focus on special populations, particularly American Indian children.
- Identify what Congress can do, particularly as it relates to the sharing of information and a federal oversight role.
- Identify what local and state governments and communities can do, particularly to promote child protection as a shared responsibility.

Individual Commissioners responded to the Chairman's presentation and outline with the following feedback:

- Overarching framing could focus on a community response versus a child welfare response, moving toward a public health response.
- Accountability has to extend beyond child protection.
- Levers should be identified to incentivize states to prioritize preventing child abuse and neglect fatalities.
- Have a strong focus on how to go about reducing the number of children who die from neglect. Bring in the public health lens but also note the need for an effective CPS that is part of an integrated approach.
- Take advantage of existing laws or strategies in place like CAPTA's Plans of Safe Care.
- There should be caution about becoming too prescriptive in the recommendations in order to give flexibility at the local level. Communities should be able to advance solutions that work best for their needs.

Based on the feedback, there was some consensus about clearly stating the problem early and then identifying five or six themes. Other areas addressed by the Commissioners included the following:

- Standardizing the definitions of child abuse and neglect fatalities and near fatalities
- Using public health language to frame the report and what that would mean

- The difference between what works and promising approaches
- Ways to promote accountability and compliance by states
- Consideration of all four levers of systems change: policy, practice, regulatory, and fiscal

Public Health Subcommittee Working Recommendations

The Public Health Subcommittee distributed a brief working document with proposed recommendations to inform the CECANF national strategy and final report. The subcommittee takes a population health approach that is premised on the belief that reducing preventable early childhood mortality will require a strong, integrated approach across the states and that a web of formal and informal systems that touch the lives of children and families must be engaged to prevent child maltreatment fatalities.

The following key points were raised during the ensuing discussion among Commissioners:

- More specificity is needed in the recommendations. Some of the areas mentioned for further exploration include substance abuse, domestic violence, unplanned births, and the need for research funding.
- Federal roles might include oversight, providing incentives for innovation, and supporting evaluation and measurement.
- The federal government should model collaboration.
- The impact of teen pregnancy and parenting must be addressed. Families should be assessed for risk factors and receive support earlier, even during pregnancy.
- It will be important to involve public systems such as law enforcement and early childhood services in these recommendations (currently heavily focused on health care).
- Also needed is a "feedback loop" to inform the federal government of any federal policies, regulations, or funding systems that might impede states' ability to make further progress.

Remarks by Chairman Sanders

Chairman Sanders announced that a six-month extension for the Commission was requested and granted. The deadline for the final report is now March 18, 2016.

WEDNESDAY, APRIL 29, 2015

Commission Deliberations

Commissioners discussed several issues related to the conversation of the previous day:

- Transparency and confidentiality and how this affects fatalities
- Sharing data across systems
- Accountability for and enforcement of federal mandates

Commissioners Rodriguez (by phone) and Petit led a conversation centered on a report from the Child Protection Subcommittee, which is focusing on short-term recommendations to avoid fatalities. Issues discussed included the following:

- Leadership at the federal level around the issue of child maltreatment fatalities

- The scope and capacity of NCANDS and its ability to gather additional data
- The role of the federal government in moving from evaluation of research to practice and policy
- Handling interstate issues around prevention of fatalities
- Compliance and quality when it comes to critical safety practices
- A multidisciplinary team approach to certain cases from the beginning and what that would look like
- A multidisciplinary look-back at cases in which children have been seriously harmed but are currently at home
- The potential creation of an "innovation fund," "time-limited enhanced funding opportunity," or "emergency fund for children," with a focus on helping to develop a predictive analytics model with formal evaluation of outcomes
- The need for federal legislation that supports and requires data sharing
- A proposal to establish a lower threshold across all states for CPS intervention "threat of harm" vs. "actual harm"
- Prioritizing responses to cases involving children ages 5 and younger through specialized teams, automatic screen-ins, supervisory review, etc.
- Prioritization of services for young parents involved in the child welfare and juvenile justice systems
- The need to clarify in what cases the Commission would recommend multidisciplinary investigative teams (e.g., child welfare with public health and/or law enforcement)
- How involvement of the criminal justice system can potentially slow the progress of child welfare cases in a way that interferes with ASFA requirements
- Ways to make the CPS response more uniformly effective across jurisdictions, such as dual-reimbursement strategies, enforcement of mental health parity requirements, and expanded access to substance abuse and mental health treatment for parents, if such strategies can be proven effective
- Unintended consequences of recommendations (for example, the potential for certain recommendations to increase racial disproportionality in the child welfare system)

Closing

General points in closing:

- The Commission will likely need further meetings beyond the New York State meeting in August, specifically for deliberations.
- Commissioners will need to reach agreement about how specific and prescriptive their recommendations will be.

The meeting adjourned at 12:30 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

9/14/15
Date