COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

UTAH PUBLIC MEETING HIGHLIGHTS—MAY 19-20, 2015

The Commission to Eliminate Child Abuse and Neglect Fatalities held a public meeting at the Sheraton Salt Lake City on May 19–20, 2015. Approximately 70 people attended via teleconference or in person. This brief provides highlights from the meeting, which explored key research, policy, and practices in the state of Utah related to addressing and preventing child abuse and neglect fatalities.

Utah Attorney General Sean Reyes was present and addressed Commissioners during the morning of Day 1. He discussed his personal involvement in efforts to prevent and intervene in cases of child sex trafficking, noting that there is likely an unrecognized connection between human trafficking and child fatalities. He recommended that the Commission reach out to organizations working on this issue. Attorney General Reyes then provided an overview of his office's involvement in efforts to reduce and eliminate child abuse and neglect fatalities. The Child Protection Division comprises 37 assistant attorney generals who work closely with the state's Division of Child and Family Services (DCFS) to obtain orders of protection, court intervention, and resources for families. The division's efforts also include participation in state child fatality reviews, an Internet Crimes Against Children Task Force, and a Trafficking in Persons Task Force. Attorney General Reyes praised the coordination occurring within the state's Children's Justice Centers, which apply the children's advocacy center model. He mentioned that the state is now working to take what it has learned from this approach to investigating and prosecuting child sexual abuse and apply it to cases of severe physical abuse and other serious crimes against children.

Other presentations by panels and individuals covered the following topics:

- Policy and practice in Utah
- Risk factors after investigation for suspected maltreatment
- Other agencies that partner with child welfare in Utah to prevent fatalities
- The Wichita, Kansas experience in reducing fatalities

For the remainder of the meeting, Commissioners engaged in deliberations about the final report and recommendations.

A full transcript and meeting minutes will be available on the Commission's website at https://eliminatechildabusefatalities.sites.usa.gov/event/utah-public-meeting/

POLICY AND PRACTICE IN UTAH

The first panel discussed the approach to child welfare services in Utah. **Lana Stohl,** deputy director of the Utah Department of Human Services (DHS), opened her remarks by noting that Utah has one of the lowest rates of child fatalities, as well as some of the lowest numbers of children entering foster care, in the country. The state has a high population of children (nearly one third of citizens are under age 18), strong family values, and a commitment to children's well-being. Stohl then discussed two statewide initiatives: a focus on prevention and early intervention and a systems of care

approach for children and families in crisis. Utah is among the first states to implement systems of care across all four major child-serving agencies (child welfare, juvenile justice, substance abuse and mental health, and services for people with disabilities). System of care values include a focus on services that are community based, family driven, individualized, coordinated across departments, youth guided (as appropriate), trauma informed, culturally competent, and evidence based. The state's system of care approach will help families identify and self-select the resources that best meet their needs. It is currently being employed in one region, and it will be rolled out statewide by 2017.

Brent Platt is the director of Utah DCFS, the state agency responsible for investigating allegations of child abuse and neglect and protecting children. Utah's child welfare program is state run and administered, with 34 offices and more than 1,000 employees in five regions. Platt focused his remarks on three areas where he feels the state is doing well:

- The state's Child and Family Team process embodies the philosophy that families know best how to protect their children. These teams are required for both foster care and in-home cases, and they may include parents, extended family, neighbors, clergy, educators, friends, and other agencies, depending on the family's needs and culture.
- The HomeWorks model program is funded by the state's title IV-E waiver. This program for in-home cases involves implementing evidence-based services, training caseworkers and giving them resources to meaningfully engage with families, and collaborating with community partners.
- The state is in the process of developing a statewide coalition of child advocacy groups to work on community-based child abuse and neglect prevention.

Platt did not have specific recommendations for the Commission but suggested that any proposed recommendations be considered in the context of child welfare finance reform.

Cheryl Dalley is the Fatality Review Coordinator for DHS. Child fatality review in Utah has been occurring since 1996 and was codified into statute in 2010. The purpose of the state's review process is to develop ways to prevent future client deaths; improve DHS services; assess whether best practices were followed; and recommend changes to procedures, policy, law, and training if necessary. Cases are eligible for review if the family received services from DCFS within the 12 months prior to the child's death. Dalley noted that the body of the reports from fatality reviews is confidential, which the state feels is important to promote free and open discussion during meetings. An annual executive summary of reviews is sent to the Office of Legislative Research and General Counsel, and a verbal report is provided to the state's Child Welfare Legislative Oversight Panel. These reports are public. They sometimes identify cross-system issues (for example, with education, law enforcement, or health care), but the review board has no authority over agencies beyond DHS.

RISK FACTORS AFTER INVESTIGATION FOR SUSPECTED MALTREATMENT

Kristine Campbell, M.D., is a child abuse pediatrician, clinical researcher, and associate professor at the University of Utah. She presented on her research into household, child, and family risk factors after a family is investigated for suspected maltreatment, exploring the question of how outcomes might be improved for children who have a history of involvement with child protective services (CPS). She began with the caveats that her research is not specific to fatalities and is not intended to scapegoat CPS, which should not be expected to bear the responsibility for protecting children alone.

Dr. Campbell drew a distinction between fixed and malleable risk factors—for example, CPS involvement is associated with future maltreatment but is not malleable (it cannot be changed after the fact). Her research found that the prevalence of malleable risk factors is high within CPS-involved households. Her research did not find, however, that the current approach to CPS involvement is effective in changing the prevalence of malleable risk. Her research did find that

when malleable risk factors (for example, the presence of intimate partner violence in the home) resolve after CPS involvement, child well-being outcomes can improve. She asserted that CPS often misses a critical window of opportunity for intervention because when an initial report is resolved, the family's case is closed, often without addressing underlying factors that affect child well-being.

Dr. Campbell recommended the following approach to improve the efficacy of CPS:

- Define the objectives (including priorities and resources).
- Identify subpopulations that are most at risk for child abuse and neglect fatalities.
- Develop and test a change theory.
- Develop programs based on a reasoned theory.
- Measure success based on the theoretical model (and recognize when programs are not working).

OTHER AGENCIES THAT PARTNER WITH CHILD WELFARE

The next panel consisted of presentations by a number of agencies that partner with child welfare to serve and protect vulnerable children and families in Utah. **LaRene Adams** of the Utah Department of Health presented to Commissioners on the Fostering Healthy Children program, which provides nurses to oversee the health of children in foster care and ensure that their ongoing physical, dental, and mental health care needs are addressed. In addition to visiting children as needed, nurses consult with child welfare staff and foster parents on health care questions, participate on Child and Family Team meetings, and attend team reviews in the case of near fatalities. There has been some discussion about extending this program to in-home cases; however, current funding does not allow for this. The program is funded through Medicaid.

Chief Greg Butler of the Woods Cross Police Department (along with another officer and a colleague from DCFS) presented on the use of the Maryland Lethality Assessment Protocol. This series of 11 questions is used by officers on scene during a domestic violence call. The process requires, at most, an additional 10-12 minutes, and Chief Butler believes that it can reduce call-backs to domestic violence situations by 60 percent across the state, saving 12-20 lives annually. When the tool was implemented in Maryland in 2005, it resulted in a 42 percent reduction in intimate partner violence homicides. Utah began implementation in 2013. The protocol is currently begin piloted in two urban and two rural areas, with plans to bring it to scale within a year. The program is funded through state general funds. An evaluation will study outcomes, including reduction in child abuse and neglect fatalities.

Robert Parrish is a deputy district attorney in Salt Lake County, assigned to the Special Victims Team. The key points of his presentation included the following:

- It is difficult to prevent fatalities and severe physical abuse when media stories misrepresent science by saying that people are being falsely convicted of shaken baby syndrome.
- Specialization of CPS workers and law enforcement officers may improve the handling of cases.
- CPS caseworker positions should be something that people aspire to, rather than being filled by people who are just getting out of social work school.
- Joint investigations between law enforcement and CPS should be mandated.
- The quality of parenting is declining—all parents need key prevention messages and to understand that they have a duty to nurture their children.

In closing, Parrish discussed a statewide effort in Utah to coordinate criminal justice and child welfare cases in the same families through Children's Justice Centers. By working together, these

teams can work out dispositions in both types of cases that avoid duplication and (in some cases) extend the timeframe for observation of families who need it.

THE WICHITA, KANSAS EXPERIENCE IN REDUCING FATALITIES

Vicky Roper and **Vera Bothner** from the Wichita Coalition for Child Abuse Prevention gave the final presentation in Utah. This broad-based coalition was formed in fall 2008 after eight child maltreatment deaths occurred that year; it currently includes 130 people representing more than 60 community agencies. It is funded through the Kansas Community-Based Child Abuse Prevention (CBCAP) funding stream.

The group has employed a number of strategies that appear to have reduced the annual number of child maltreatment deaths in that community to near zero. One such approach is moving from a focus on the isolated impact of individual agencies to a collective impact approach that requires a common agenda, shared measurement strategies, mutually reinforcing activities, continuous communication, and backbone support. They also employ a Strengthening Families approach that focuses on protective factors and safe, stable, and nurturing relationships and environments. They have implemented the Period of PURPLE Crying materials and established a crisis nursery project, among other strategies. The local police department, child welfare office, and health department all have played critical roles.

Vera Bothner, a strategic communications consultant who assisted the coalition, argued that the public's attention span is very short (8 seconds) and that consistent, clear, and simple messages are critical to reach the public effectively around this issue. She urged coalitions like the one in Wichita to be as proactive and consistent as possible in their communication. She also pointed out that stories often have a greater impact than statistics.

Their recommendations for replication included the following:

- Use the Collective Impact model and training.
- Require the engagement of certain partners (e.g., child welfare, law enforcement, hospitals, health departments).
- Conduct a process evaluation.
- Publish a media guide.
- Use CBCAP funding.
- Publish a monograph with lessons learned and contact information for communities who have done this work.

COMMISSIONER DELIBERATIONS

Public Health Subcommittee

Public Health Subcommittee members recently met with the Home Visiting Research Network, which conducts national evaluations on home visiting models. That meeting focused on the following issues:

- The Commission was cautioned against endorsing a particular model and was encouraged instead to focus on components of effective home visiting. No discrete model has been found to be more or less effective at preventing child abuse and neglect fatalities.
- There are opportunities to better integrate home visiting services, particularly within the concept of medical homes.
- The home visiting research collaborative provided recommendations for testing the relationship between home visiting and child maltreatment deaths.

- The network emphasized the importance of encouraging data sharing across federal systems for research purposes.

The Subcommittee continues to look for evidence of the relationship between mental health and substance abuse treatment and a reduction in child fatalities. They also are pursuing analysis around dual-generation reimbursement strategies and providing services to parents through pediatric medical homes. The Subcommittee urged the Commission to consider various avenues for increasing federal accountability around this issue. Discussion continued around whether the term "public health approach" appropriately describes what the Commission is recommending (an upstream, data-informed prevention strategy that involves partners beyond CPS). Also, there is some concern that resources not be shifted away from CPS, where services will still be needed for families in crisis.

Themes and Recommendations

The remainder of the meeting in Utah consisted of Commissioner discussion regarding proposed recommendations (including those gathered from researchers at the Commission's Research Roundtable in December) and themes for the Commission's final report.

Commissioners raised the following issues in discussion, some of which will be addressed in more detail in upcoming meetings:

- Identification of effective and ineffective programs (currently funded)
- Accountability when a child dies under the protection of a government agency (e.g., in foster or residential care)
- Public disclosure of information about child abuse and neglect fatalities
- Clinical practice guidelines for CPS
- Consideration of protective factors
- Increased vulnerability of children with disabilities