COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

WISCONSIN PUBLIC MEETING HIGHLIGHTS—JULY 15-16, 2015

The Commission to Eliminate Child Abuse and Neglect Fatalities held a public meeting at the Madison Marriott West in Middleton, Wisconsin, on July 15–16, 2015. Approximately 75 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 Wisconsin related to addressing and preventing child abuse and neglect fatalities.

Two state officials appeared before the Commission during this meeting. **Fredi-Ellen Bove**, the administrator for the Division of Safety and Permanence (DSP) at the Wisconsin Department of Children and Families (DCF), opened Day 1 by providing an overview of Wisconsin's child welfare system, state statistics on child maltreatment fatalities, and information about the DCF approach to safety decision-making. Wisconsin's child welfare system is almost completely county administered. This has some benefits: Local agencies are aware of local needs, have the flexibility to test system enhancements, and are better able to collaborate with other human service systems. However, inconsistencies exist in county funding, resources, and service quality, and rural counties have difficulties developing specialized expertise and covering isolated areas.

According to Bove, analysis of Wisconsin data on maltreatment-related deaths and near deaths of children points to two populations that should be targeted for prevention and intervention services: families with open cases where children are still at home and families with previous child welfare system involvement. The state's analysis also confirms that a significant proportion of children who experience fatalities or near fatalities are unknown to the child welfare system prior to their death, reinforcing the need for participation by a range of community partners in prevention efforts. Wisconsin is using a title IV-E waiver to allow some counties to check back with families during the postreunification period—Bove noted that all states would benefit from greater flexibility to use title IV-E funds for prevention services. To help maintain children's safety while avoiding the trauma of removal whenever possible, Wisconsin uses a modified version of the ACTION for Child Protection Safety Model to support systematic safety decision-making. The state has been targeting supervisors for intensive training about safety decision-making since 2012.

Eloise Anderson, the secretary of the Wisconsin Department of Child and Families, opened the second day of the meeting. Secretary Anderson began her presentation by listing common risk factors for child maltreatment in Wisconsin. Typically, she suggested, it is a combination of multiple factors (rather than a single risk factor) that brings families into the system. Secretary Anderson also pointed out that child welfare systems are typically well equipped to deal with abuse but need to become more trauma-informed to address neglect more effectively. She suggested that child welfare systems can use what is known about child maltreatment to address fatalities by focusing on early intervention, strengthening families, and building community connections. She then provided examples of these approaches in Wisconsin, including home visiting, postreunification services, domestic violence, and Families and Schools Together (FAST). Secretary Anderson closed her comments by echoing Bove's earlier request for greater flexibility for states in the use of title IV-E funds.

Other presentations by panels and individuals covered the following topics:

- Proactive safety management: Lessons from high-risk industries
- Family structure and child abuse and neglect fatalities
- Issues affecting American Indian/Alaska Native children and families
- Oversight and accountability for performance in child protection
- Strengthening child safety through partnerships with health
- Wisconsin's safety protocols

For the remainder of the meeting, Commissioners engaged in deliberations.

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

PROACTIVE SAFETY MANAGEMENT: LESSONS FROM HIGH-RISK INDUSTRIES

This presentation drew upon lessons learned from high-risk industries, such as the airline industry, to offer proactive safety management guidance for child protective services (CPS). **Dr. David Woods**, a professor at Ohio State University and expert on safety in high-risk industries, spoke about the need to approach CPS as a system that is the sum of interactions among its parts—simply replacing one part with a better version will not result in significant improvement. He used examples from a variety of fields, including the Cerro Grande fire of 2000, to illustrate the need to look beyond human error at the many factors that result in system failure and the multiple points in a system where a change could have averted disaster. Dr. Woods was joined by **Dr. Eileen Munro** of the London School of Economics, who was recently hired by the British government to review England's child welfare system and make recommendations to improve safety. Dr. Woods and Dr. Munro offered the following recommendations to Commissioners:

- Reinvent CPS investigations to improve hindsight bias and see system interactions.
- Grow and share expertise by studying how people create success.
- Rebalance the conflict between documentation and service provision so that caseworkers have adequate time to provide services to families.
- Design, energize, and sustain a campaign for systems change that includes culture change and comes from the top.
- Design innovative ways to cope with the reality of being chronically underfunded.

FAMILY STRUCTURE AND CHILD ABUSE AND NEGLECT FATALITIES

Dr. Mitch Pearlstein, founder and president of Center of the American Experiment and an expert on family fragmentation in America, presented research showing that children are safer when residing with their two married, biological parents. As early as 2002, the *Journal of Pediatrics* published a study showing that children not residing with two biological parents were eight times as likely to die from abuse or neglect as children living with both biological parents. Dr. Pearlstein urged the Commission to include a discussion of the importance of married parents when exploring ways to increase safety for children.

ISSUES AFFECTING AMERICAN INDIAN/ALASKA NATIVE CHILDREN AND FAMILIES

The next panel consisted of presentations by three agents of the Bureau of Indian Affairs (BIA). **Jerin Falcon**, in the Office of Justice Services in District VII, was joined by **Valerie Vasquez** and **Kerma**

Greene from the Midwest Region. As background, the presenters noted that there are 567 recognized tribes, and these tribes operate as sovereign nations, with a government-to-government relationship with the United States. Some of these tribes have contracts or compacts with BIA to provide services; others do not. Tribes vary considerably in terms of their resources, their relationships with states, and their funding sources (including whether or not they choose to apply for title IV-E funding). Complex jurisdictional relationships further complicate how child abuse and neglect are addressed in Indian Country. Panelists then touched on a number of issues that ultimately affect children and families.

Lack of data was cited as one of the most crucial issues, with far-reaching consequences. Neither tribes nor the BIA collects sufficient, usable fatality data that distinguishes children from adults as victims and that notes incidents of child abuse and neglect. Falcon suggested that moving to the Department of Justice's National Incident-Based Reporting System (NIBRS) would be a vast improvement, but most tribes currently do not have any way to record and report with NIBRS. Data collection and analysis would allow tribes to determine not only what is leading to fatalities, but also what is working well to keep children safe. Greene offered three specific recommendations: Work with tribes to develop reporting requirements for tribal child abuse and neglect fatalities, provide tribes with funding to build capacity and infrastructure to capture the necessary data, and develop a longitudinal research report that documents the specific factors leading to child abuse and neglect fatalities in Indian Country.

OVERSIGHT AND ACCOUNTABILITY FOR PERFORMANCE IN CHILD PROTECTION

Three panelists spoke on the topic of accountability. **Dr. Mark Testa**, a professor in social work at the University of North Carolina and a child welfare expert with extensive experience in evaluation, led off the panel with a presentation on results-oriented accountability (ROA). ROA can serve as an alternative to the compliance-oriented accountability that most states currently use by promoting investment in evidence-based approaches, such as subsidized guardianship, Nurse-Family Partnership, and postpermanency support for families. Dr. Testa argued that states should be allowed the flexibility to change almost any aspect of federally mandated laws on a trial basis in order to test new approaches. This experimentation should follow the circular Cycle of ROA: data analysis, research review, evaluation, quality improvement, and outcomes monitoring. He concluded his presentation with an illustration from Cuyahoga County, Ohio, in which ROA was used to reduce the time in foster care for children from homeless families.

The second presenter, **Amy Harfeld,** serves as the national policy director and senior staff attorney for the Children's Advocacy Institute (CAI) at the University of San Diego School of Law. Her institution has published two versions of the report *State Secrecy and Child Deaths in the U.S.*, which grades states on their public disclosure of the circumstances around child deaths and near deaths. Harfeld suggested that more complete public disclosure, including information about a child's prior agency contact, would lead to more effective prevention of child deaths. She also urged the Commission to recommend clarification and strengthening of the Child Abuse Prevention and Treatment Act (CAPTA) requirements around public disclosure of fatalities and near fatalities, more robust and stronger enforcement of these requirements, and resources to align funding with Commission recommendations.

Kathleen Noonan, founding co-director of PolicyLab at the Children's Hospital of Philadelphia (CHOP) and a professor at the University of Pennsylvania, then presented on the use of consent decrees to improve child welfare systems. Although many advocates view consent decrees as an accountability tool, some child welfare agencies question this approach. Most class action cases (consent decrees) are focused on permanency for children in foster care, rather than safety. Most target the child welfare agency alone, without regard to other systems. Noonan stated that a lot of consent decrees have *not* resulted in better systems, but there has been some improvement in

recent decrees. She cited Utah as a state where the consent decree resulted in positive change in the child welfare system. She also suggested that child welfare might be better served by the approach that hospitals take, in which they get together and share lessons learned.

STRENGTHENING CHILD SAFETY THROUGH PARTNERSHIPS WITH HEALTH

Two panelists provided information about Wisconsin programs that partner child welfare and health. **Mark Lyday**, director of Child Advocacy and Protection Services (CAPS) programs at the Children's Hospital of Wisconsin, spoke about ways that the hospital addresses child abuse fatalities. A statewide public-private partnership, the Wisconsin Child Abuse Network, seeks to increase medical expertise about child abuse among (1) medical providers who might see children suspected of being abused and (2) law enforcement and CPS workers who must determine whether children have been abused. Lyday also spoke about the Milwaukee Child Abuse Review Team (CART), a multidisciplinary team whose goals are to maximize safety, carry out successful prosecution, and minimize revictimization. Other CAPS activities include operating seven children's advocacy centers, reaching out to offer services to screened-out families, and working closely with domestic violence service providers to coordinate interventions. Lyday offered the following recommendations:

- Engage health care systems in efforts to reduce child abuse and neglect deaths.
- Use multidisciplinary training to change culture.
- Mandate a multidisciplinary response informed by medical science.
- Eliminate siloed approaches in responding to family violence.
- Study near misses.

The second panelist, **Cynthia Johnson**, is the director/health officer of the Kenosha County Division of Health. Kenosha County focuses on the use of two home visiting programs—Nurse-Family Partnership and Parents as Teachers—to prevent child fatalities. The goal of both programs is to increase parent-child attachment and parents' self-efficacy. To date, these programs have shown positive results through a reduction in African-American infant mortality in the county. Johnson's recommendations included expansion of federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funds, tax incentives for impoverished families, creating a "culture of work," monthly disbursement of the earned income tax credit, and a focus on improving mental health and dental services for low-income families.

WISCONSIN'S SAFETY PROTOCOLS

The meeting's final panel included four Wisconsin child welfare workers: **Kirk Mayer**, an initial assessment specialist at the Bureau of Milwaukee Child Welfare (BMCW); **Tara Muender**, Initial Assessment Training Team supervisor for BMCW; **Kelly Oleson**, Youth Services Manager in Adams County; and **Julie Ahnen**, CPS services manager for Dane County. They offered a variety of perspectives on the state's safety decision-making model and discussed its benefits and challenges. The workers reported that the safety protocol helps workers gather comprehensive information and increases consistency and confidence in decision-making. Some of the challenges discussed include the difficulty of addressing cases that indicate danger but do not reach the protocol's danger threshold and problems specific to serving a very rural county that lacks available services.

Recognizing the importance of the supervisory role, Wisconsin is implementing a new model called Supervising Safety Decision-Making. By training supervisors in this model, the state is beginning to see improvements in social workers' information-gathering and assessment performance. Decisions are more consistent, and workers are more confident. Communication with families also has improved. There have been fewer removals, and safety plans are better structured and easier for families to understand. In addition, safety assessments now occur throughout the life of a case, and

all safety decisions about children under 2 years of age are reviewed by a minimum of two supervisors to ensure heightened awareness of the most vulnerable children.

The CPS services manager reported that she reviews selected screened-out cases and participates on the Fetal and Infant Mortality Review team, with a specific focus on infant deaths related to unsafe sleeping. The manager noted that there are often elements of domestic violence and isolation of families in fatalities and near fatalities, so the child welfare agency tries to reach out to isolated families that will not seek support on their own.

COMMISSIONER DELIBERATIONS

Public Disclosure

At the end of the first day of this meeting, the Commissioners engaged in deliberations around the importance of public disclosure of information about child abuse and neglect fatalities. Those who argue against disclosing this information cite the need for confidentiality for surviving (nonoffending) family members and the desire not to undermine criminal investigations. Those in favor of more disclosure suggest that transparency holds systems accountable and allows them to learn from past mistakes. The general consensus among Commission members was that the emphasis should be on identifying and addressing problems within systems, rather than seeking to assign blame. However, alerting the public to these fatalities (without identifying information that could retraumatize survivors) may help with prevention, particularly if such disclosure is accompanied by information about what members of the public can do to contribute to child safety in the future. Some ways to support systems improvement might be to strengthen federal statutes requiring disclosure, conduct analysis of fatality data that are gathered at the federal level, and provide child welfare agencies with guidance on effective practice for public disclosure of information when a fatality occurs.

Policy Subcommittee

The Commission's Policy Subcommittee presented its draft recommendations for discussion on Day 2. The Subcommittee's approach was based on the principles that child safety must be paramount and that recommendations should be feasible and make a measureable difference in eliminating fatalities. To reach its conclusions, the Subcommittee analyzed policy from a variety of systems, including child welfare, law enforcement, health care, education, and others. Its organizing principles were the need for clarification, accountability, effectiveness, and efficiency. The Subcommittee will continue to refine its recommendations based on input from the Commissioners.

American Indian/Alaska Native Subcommittee

The AI/AN Subcommittee took a slightly different approach from other Subcommittees to develop its recommendations. They reviewed transcripts of verbal testimony from all speakers who presented before the full Commission and presented a list of all of these speakers' recommendations on jurisdiction, data, service delivery, and coordination across states/federal/tribes. In every instance, the Subcommittee made an effort to be respectful of AI/AN voices and cultures. Commissioner discussion at this meeting centered around how best to represent this process and the resulting recommendations in the Commission's final report.

Discussion of Final Report

Commission members concluded the meeting with a discussion of the need to begin to organize their agreed-upon findings and recommendations under a central principle or core recommendation. There will be further discussion of this at a future date.