COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MEETING MINUTES
July 15-16, 2015

Meeting Location: Madison Marriott West, 1313 John Q. Hammons Drive, Middleton, WI 53562

Commissioners Present: Chairman David Sanders, Dr. Cassie Statuto Bevan, Susan Dreyfus, Dr. Wade Horn, the Hon. Patricia Martin, Michael Petit, Dr. David Rubin, Jennifer Rodriguez, and Marilyn Bruguier Zimmerman

Not in attendance: Amy Ayoub, Theresa Covington, and Bud Cramer

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 Wednesday, July 15, 2015, from 8:00 a.m. to 5:30 p.m., and Thursday, July 16, 2015, from 8:00 a.m. to 12:30 p.m., at the Madison Marriott West, Middleton. The purpose of the meeting was for Commission members to gather national and state-specific information regarding child abuse and neglect fatalities, including testimony on the following topics:

- Lessons on safety from high-risk industries
- Issues affecting American Indian/Alaska Native children
- Accountability for protecting children
- Wisconsin's strategies for preventing child fatalities

Commission members also discussed the work plans of the Commission subcommittees and the information that they have obtained to date.

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.

WEDNESDAY, JULY 15, 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 Wisconsin Leadership: *Fredi-Ellen Bove, Administrator, Division of Safety and Permanence, Wisconsin Department of Children and Families (DCF)*

Fredi-Ellen Bove, administrator in the Wisconsin DCF, welcomed the Commission to Wisconsin and gave a presentation on the state's approach to child safety. Bove focused on three areas:

- The dynamics of a county-administered system
- Data analysis on deaths and near fatalities in Wisconsin
- Wisconsin's approach to safety decision-making in the child welfare system

As background, Bove explained that Wisconsin is a county-administered child welfare state with the exception of Milwaukee County, where child welfare is administered by the state through DCF. The state assumed responsibility for Milwaukee County in 1998 in response to a lawsuit. Outside Milwaukee, child welfare is delivered by 71 county child welfare agencies. Strengths of local administration include the following:

- Agencies are knowledgeable about their local needs and use strategies and priorities specific to those needs.
- There is flexibility to test innovations at the local level.
- There are opportunities for cross-system collaborations with county mental health and other county agencies.

There are also a number of key challenges in a county-based system:

- Resources and funding vary widely across the state.
- It is difficult to develop specialized expertise, such as providing services for drug-positive infants, in small and rural counties that have limited staff. In addition, some of the smaller counties' functions are less cost effective.
- It is difficult to ensure consistency in quality of services across the state.
- Broadening the use of innovative practices does not always happen because of lack of resources, lack of widespread interest, or the complexity of scaling up.

The state's management of the Milwaukee child welfare system offers the advantages of (1) providing DCF with a pilot site for new approaches that can be tested and tweaked before being rolled out statewide and (2) providing DCF with direct exposure to the issues and challenges of running a child welfare system.

Bove also noted that smooth functioning of the county-administered system is highly dependent on close collaboration between the state and counties. While this generally prolongs the time for development and rollout of new practices, it also can lead to a more successful implementation and rollout, because the county buy-in grows during that development process.

Bove also spoke about child maltreatment deaths and near deaths in Wisconsin. She noted that Wisconsin has a maltreatment-related public disclosure statute that is broader than in most states and requires DCF to report not only maltreatment-related deaths, but also egregious incidents and serious injuries. Egregious incidents include violence, torture, restraints, and other kinds of aggravated circumstances. Serious injuries are incidents in which a child has been diagnosed by a physician in serious and critical condition.

DCF conducted analyses on all substantiated maltreatment-related deaths during 2009 to 2013 and found the following:

- Of the 118 substantiated maltreatment deaths, fewer than 2 percent involved children in an open child welfare case and in out-of-home placement.
- A larger proportion, 16 percent, were in open child welfare cases but were still with their families.
- A significantly larger proportion, 44 percent, of the children were not in open cases but had previous child welfare involvement, and that included screened-in and screened-out cases.
- Another significant proportion, 38 percent, of the children who died from maltreatment had no current or prior involvement with the child welfare system.

When these findings were compared to findings from an analysis of all 141 near fatalities (serious incidents, egregious incidents, and serious injuries) during 2013 to 2014, a similar pattern of findings emerged. Bove stated that these similar results highlight the fact that there are two vulnerable and identifiable populations that could be targeted for services to prevent child fatalities and other types of child abuse and neglect:

- The first group is families with open child welfare cases where children are still in the home.
- The second group is families with previous involvement with the child welfare system.

The fact that a significant number of child maltreatment fatalities involve children never known to the child welfare system implies that eliminating fatalities is a community responsibility and not just a responsibility of the child welfare system.

Bove also pointed out that title IV-E funding cannot be targeted for the two known vulnerable populations, because that money's use is restricted to children in out-of-home care. Wisconsin and other states would benefit from federal action to increase the flexibility of federal title IV-E funds so that funding could be used to support timely and effective in-home services.

Bove discussed the safety decision-making model employed by child welfare workers throughout the state in an effort to balance child safety with the desire to keep children with their families whenever possible. Workers use a modified version of the ACTION for Child Protection Safety Model as a tool to help them think critically and systematically about safety decision-making. Child welfare supervisors guide workers during information collection and assessment work, and supervisors must approve any decision regarding whether children are removed or remain with their family. Supervisors receive intensive training on safety decision-making.

Commissioner Discussion

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

- It is too early to determine whether the rollout of the new decision-making model is having an impact on fatalities and near fatalities.
- Wisconsin follows a three-part process of releasing information after a child maltreatment-related death or near fatality. The state releases basic information within two to five days, which includes the child's age and county. Within 90 days, the state releases a more complete summary, which is published on the DCF website. Then, if an internal review is done, that is also released. The names of the child and family are never included.

- It could be useful to go back to the analyses on fatalities and near fatalities to do more in-depth research on the status of the families with regard to child welfare involvement.

Proactive Safety Management: Lessons for CPS From High-Risk Industries: *Dr. David Woods, Ohio State University*, and *Dr. Eileen Munro, London School of Economics*

Dr. David Woods, a professor of integrated systems engineering at Ohio State University, and Dr. Eileen Munro, a child welfare expert at the London School of Economics, spoke about applying safety knowledge gained from high-risk industries to prevent child maltreatment fatalities. Dr. Woods introduced the concept of proactive safety management and spoke about its application across a number of industries. He also mentioned that his early work was with hospital patient safety. Dr. Munro offered examples from her work in evaluating the British child welfare system to illustrate some of Dr. Woods' points on proactive safety management.

Dr. Woods noted that systems do what they are designed to do—even if that is not what they were intended to do. Changing out components does not make the system work differently. Well-intended interventions that focus in isolation on components and pieces end up missing the interactions and not producing the desired effects and—even worse—producing counterproductive effects. Dr. Munro supported these statements by noting that child welfare reforms in England always seemed good in isolation, but they did not work in the real world where there were many complex interactions that needed to be taken into account.

Dr. Woods illustrated his points using the example of the Cerro Grande Fire accident. The Cerro Grande Fire was set on purpose as a controlled burn, but it grew out of control due to high winds and drought and ended up burning for six weeks and causing $1 billion in damages. Lessons learned from the Cerro Grande Fire include the following:

- Escape hindsight bias. Knowledge of the outcome causes bias in judgments about the process that led up to the outcome.
- Look for multiple contributors at all levels when investigating a bad result—not just one person or one cause.
- Understand the difference between work as imagined and work as actually practiced—and the competing goals that each brings.

Dr. Munro noted that British child welfare investigations are now starting to change to involve more agencies and services than just CPS—for instance, police, teachers, and doctors. All of their information is collated to give a more complete picture of a case. She also noted that individual caseworkers offer a lot of good input when asked about indicators or ways to be proactive.

Dr. Woods and Dr. Munro made the following recommendations to improve child welfare work:

- Reinvent investigations to escape hindsight bias and see system interactions, crunches, bottlenecks, dilemmas, blunt ends, and latent factors.
- Grow and share expertise. Study how people create success—for instance, how the best caseworkers and units handle difficult situations.
- Rebalance the conflict between documentation and the actual work of helping children.
- Design, energize, and sustain a campaign. Systems and culture change need to start at the top and catalyze all roles. Weaknesses should be addressed before waiting for failures.
- Innovate ways to cope with being chronically underfunded.

- Create foresight to anticipate the changing shape of risk before failure or harm occurs.

The Commissioners asked questions throughout the presentation, and the responses by Dr. Woods and Dr. Munro were woven into the presentation.

Family Structure and Child Abuse and Neglect Fatalities: *Dr. Mitch Pearlstein, Center of the American Experiment*

Dr. Mitch Pearlstein, founder and president of Center of the American Experiment, a conservative and free-market think tank in Minneapolis, spoke about family fragmentation and its impact on child abuse and neglect. Dr. Pearlstein stated that significantly increasing the rate of healthy and violence-free marriages in the United States would lead to less child abuse and fewer child deaths. While there are millions of children growing up in single-parent families and doing well and millions more growing up in two-parent family homes and not doing well, research shows that children in general do better when they grow up with two married parents.

He offered the following statistics:

- The United States likely has the highest family fragmentation rate in the industrial world, with 40 percent or more of all American children now born to single mothers.
- This rate is even higher among particular groups.
- Cohabiting relationships have exploded in the last few decades.
- Although teenage birth rates have declined in recent years, teenage girls who do have a child rarely marry the baby's father.
- Overall divorce rates are generally estimated at between 40 percent and 50 percent.

Dr. Pearlstein noted that children are not well served by these trends. He noted two outstanding impacts:

- In 2002, the *Journal of Pediatrics* wrote, "Children residing in households with adults unrelated to them were eight times more likely to die of maltreatment than children in households with two biological parents."
- Other research has shown that although boyfriends contribute less than 2 percent of nonparental care, they are responsible for half of all reported child abuse by nonparents.

Dr. Pearlstein then reported that he had searched 15 sets of minutes and highlights of previous meetings of the Commission for references to marriage and had found only two references to the word "unmarried" (in minutes for the Commission's hearing in Denver) and one irrelevant reference to the word "marry" (in minutes for the hearing in Portland, Maine). This lack of consideration for the impact of marriage on child abuse and neglect parallels an ongoing series of events in Minneapolis and St. Paul. The report of an investigation into the causes of more than 50 child maltreatment-related deaths never made a reference to family fragmentation.

In the interest of time, Dr. Pearlstein condensed his recommendations to one main point: We need to retrieve our voice about marriage. While the importance of fathers is now more widely recognized than it was, many people laud father involvement but stop short of recognizing marriage and its distinctive and essential contributions. This does not serve children. Decades of rigorous research have demonstrated that boys and girls growing up in two-parent families, on average, do better than other children in every realm, including avoiding abuse and child death.

Commissioner Discussion

The following points emerged from questions and answers between the Commissioners and Dr. Pearlstein:

- In addition to more open talk about the importance and benefits of marriage for children, there also needs to be more emphasis on helping boys become marriageable men.
- There also should be more research on effective parenting by single parents.
- Research on promoting healthy marriage has not been successful in many cases; however, a federally funded study that provided a skills-based approach to helping low-income couples develop better relationship skills did show some success.
- Dr. Pearlstein endorsed charter schools, especially religious charter schools, as offering a safe and loving place for some children.

Issues Affecting American Indian/Alaska Native (AI/AN) Children and Families: *Panel Presentation*

Commissioner Zimmerman offered a few background remarks on child welfare on Indian reservations, noting the differences between states and tribes in laws and procedures, jurisdiction, and data collection. She then introduced the panel of three from the federal Bureau of Indian Affairs (BIA), who presented on child abuse and neglect fatalities in Indian Country.

Valerie Vasquez, Midwest Region, BIA

Valerie Vasquez, a regional social worker for the BIA, provided a brief overview of the BIA and the tribal relationship. She noted the following:

- There are 567 federally recognized tribes.
- The BIA has varying degrees of involvement with any particular tribe.
- Tribes often exercise their sovereign rights as independent nations and are very autonomous.
- Tribes are different from one another in customs, culture, belief systems, and government, including governing their own communities.
- Some tribes have partnered with their respective states and have agreements, or Memoranda of Understanding, for child protection investigations.
- Some tribes are in Public Law 280 states, which affects state/tribal jurisdictional issues.

The BIA ties its relationship to any specific tribe through a contract (for 638 tribes), which means that their funding flows through the BIA, or a compact (for self-governance tribes), which means that tribes receive funding directly. All responsibilities involving the BIA/tribal relationship are outlined by regulation.

Data collected on child abuse and neglect, including child maltreatment fatalities, are not comprehensive and do not reflect what is happening to tribal children.

Jerin Falcon, Office of Justice Services, BIA, District VII

Jerin Falcon, a special agent in charge for the BIA Office of Justice Services for District 7 (Minnesota, Michigan, Wisconsin, Iowa, and Illinois), presented on issues with data collection on reservations. Falcon's office oversees about 25 tribal police departments.

Falcon noted that the difference between tribes in Public Law 280 states and those in other states is that Public Law 280 states opted to assume criminal jurisdiction over most tribes in their state. This has an impact on child abuse data, because Public Law 280 states do not distinguish child abuse fatality cases on reservations from other child abuse fatality cases in their state, and there is no way to track the tribal cases. When a child dies from maltreatment on a reservation, the death is not recorded as a tribal death in those states.

In the states that did not opt in to Public Law 280, there is only federal and tribal jurisdiction. Misdemeanors are handled by tribes, and anything at the felony level and above is handled by the BIA, FBI, or other federal agency. Current data collection for Indian Country includes the FBI uniform crime reports; unfortunately, those files do not differentiate between child and adult homicide victims. A shaken baby case is a homicide in the FBI records, and there is no a way to indicate that the victim was a child and was a victim of child abuse.

Falcon recommended moving from the current FBI reporting system to the National Incident-Based Reporting System (NIBRS), which the FBI does have. The main benefit of the NIBRS is that the system collects much more detailed data on the victim, perpetrator, and circumstances surrounding the maltreatment or other incident.

Kerma Greene, Midwest Region, BIA

Kerma Greene of the BIA Midwest Region reported on recommendations to the Commission that would help improve data collection and address child maltreatment fatalities in Indian Country. Recommendations included the following:

- Develop reporting requirements for tribes, and provide training and technical assistance to tribes about how and why the data on child abuse and neglect and child maltreatment fatalities are collected.
- Increase funding in Indian Country for health services, domestic violence, child welfare programs, law enforcement, and judicial systems.
- Research and develop a longitudinal report on the factors leading to youth fatalities.
- Research the use and effectiveness of child abuse and neglect prevention programs with tribes.
- Develop a system to capture comprehensive data and link information among the different agencies involved.

Commissioner Discussion

In the questions and answers that followed the BIA presentation, the following points were made:

- States that do not have good working relationships with their tribes should look to states like Wisconsin and Washington, which have worked out good relationships.

- States that honor the Indian Child Welfare Act and behave respectfully toward tribes will have better relationships with those tribes.
- Currently, when a child or family involved in child welfare identifies as Indian, that information is not reported to the BIA or elsewhere, so it is not generally tracked.
- The FBI Uniform Crime Reports are supposed to collect information on homicide, sexual assault, and child abuse, but the information lacks much of the detail that would be useful to know about child abuse fatalities.
- One recommendation to the Commission is to make it easier for tribes to achieve eligibility for IV-E funding; however, it is not clear how to do that while still maintaining safety for children.
- There are disparities between state child welfare workers and workers on reservations in terms of education, training, and experience; tribes often cannot afford to hire trained and experienced workers. In some cases, jobs go unfilled.

Oversight and Accountability for Performance in Child Protection: *Panel Presentation*

Three panelists presented different perspectives on the topic of accountability in child protection and child welfare.

Dr. Mark Testa, University of North Carolina at Chapel Hill

Dr. Mark Testa, a professor at the School of Social Work at the University of North Carolina, opened the presentation with a discussion of the difference and tension between responsibility and accountability for child abuse and neglect fatalities.

- Dr. Testa noted that child welfare authorities are held accountable for safety outcomes—even when they are only incompletely responsible for the conditions necessary for safe parenting.
- This tension between accountability and responsibility also occurs for birth parents: They are responsible for the safety, care, and well-being of their children, but they are not publicly accountable to anyone for their parenting practices, except in the narrow sense that they should not violate child abuse laws.
- This incomplete overlap between accountability and responsibility for a child creates tensions that can be resolved when a child welfare agency takes full responsibility for a child, such as when a child is removed from parents and placed in foster care.
- Alternatively, the tension may be reduced by narrowing the accountability of the public agency or court so that they have both weak accountability and weak responsibility.

To resolve these issues, Dr. Testa argued that what is needed is a new system of results-oriented accountability, which has the following characteristics:

- It operates on the premise that public authorities are accountable for outcomes that are their responsibilities only in an incomplete way.
- It requires working with other systems that have weak accountability and weak responsibility, such as hospitals, schools, the military, prisons, and the Department of Homeland Security.
- It also requires building evidence for the validity of the effectiveness of interventions as well as ensuring the integrity with which interventions are implemented.

Dr. Testa stated that results-oriented accountability, which includes accountability for both intervention validity and implementation integrity, is a new phase in the evolution of public accountability, following up on two other phases:

- The first phase was compliance-oriented systems. Compliance in and of itself has not been enough to improve outcomes, thus producing an efficacy gap.
- The next phase was outcomes-oriented accountability, which shows whether something did or did not improve, but it does not show why. That reproducibility gap creates special challenges in how to scale up successful interventions.

Results-oriented accountability is intended to address the efficacy gap and the reproducibility gap, recognizing that otherwise valid interventions do not always succeed because of improper implementation, poor fidelity to the proven design, or failure to reach enough of a target population. This was a lesson learned from the Nurse-Family Partnership and the Head Start experiments, which showed that effective interventions can be undermined if not implemented with fidelity to the proven design.

At the same time, faithful implementation that does not result in the expected outcomes indicates that the intervention was weak on validity. This was a lesson learned from many of the compliance-oriented consent decrees and in the replication of the differential response program in Illinois.

Results-oriented accountability builds on these three principles:

- Evidence-based: A problem cannot be understood until there is an evidence-based solution that works.
- Collective impact: System-wide responsibility is required.
- Family-focused: Preventing child maltreatment and reversing its adverse effects on future health and well-being are best addressed within the context of safe and permanent family relationships.

These three principles are the basis of a lot of federal government-funded solutions. Bipartisan endorsement of results-oriented accountability has emerged, and researchers are calling for the building of evidence by testing interventions and subjecting their implementation to controlled experimentation using some type of random assignments.

Dr. Testa recommended that within extremely broad limits states should be permitted to change almost any aspect of federally mandated laws and policies on a trial basis. One of the Commission recommendations should be for federal waivers to be a permanent part of the IV-E funding. This cycle of results-oriented accountability has become the blueprint for a framework to design, test, spread, and sustain effective practices in child welfare. It is also the blueprint being used for the Children's Bureau's Quality Improvement Centers.

Dr. Testa illustrated the use of results-oriented accountability by describing Cuyahoga County's pay-for-success initiative to reduce long-term foster care, which followed this sequence:

- The child welfare agency looked at the interrelated nature of child welfare problems and discovered that 30 percent of the parents of children who came into foster care were involved in the homeless system.
- The agency worked with homeless authorities, identified problems and practices, and then began developing a randomized cost comparison design to see exactly whether and how effectively they could reduce long-term foster care.

- They used the results-oriented accountability strategy of developing a PICO (population, intervention, comparison, outcome) question. Their question was the following: Can length of stay in foster care be reduced by 25 percent among foster children of homeless parents if families receive supported housing assistance, critical time intervention, and trauma-adapted family connections, compared to children who receive supported housing assistance and other services as usual?
- Results are not yet in.

Amy Harfeld, Children's Advocacy Institute

Amy Harfeld, the national policy director and senior staff attorney at the Children's Advocacy Institute, based at the University of San Diego School of Law, focused her presentation on the public disclosure aspect of child fatalities. Harfeld began her legal career litigating child abuse and neglect cases for the City of New York and understands the burdens placed on local and state agencies.

The Children's Advocacy Institute conducts advocacy on a variety of issues on behalf of vulnerable children, especially child welfare and foster care. Since 2007, the institute has focused on child abuse and neglect fatalities, publishing two editions of *State Secrecy and Child Deaths*, in 2008 and 2012. A third edition of this report is underway. This report came about when the institute learned that many states were grossly out of compliance with requirements under the Child Abuse Prevention and Treatment Act (CAPTA) that mandate public disclosure about child abuse fatalities. The institute analyzed and graded each state on whether they were complying with the law. Response to the reports has been mixed. Some states, such as Utah, Georgia, and Tennessee, improved their grades dramatically between the two editions of the report. Many other states made positive changes.

The institute provided copies of the reports to the Children's Bureau and met with top officials at the Administration for Children and Families (ACF). However, ACF was not prepared to enforce punitive measures on states that were out of compliance with the CAPTA requirements for public disclosure nor levy sanctions, penalties, or public censure.

With the 2010 reauthorization of CAPTA, Congress instructed ACF to develop clear guidelines in the form of regulations instructing states of their responsibilities under CAPTA to release public information in cases of child fatalities and near fatalities. The Children's Advocacy Institute provided ACF with suggested language, but ACF noted that this time-consuming and complicated effort required further input from the states first.

Currently, there are no regulations to make it clear to states that they must release this information. Harfeld noted that ACF had made motions to amend the nonbinding *Child Welfare Policy Manual* to address some of these concerns. However, the current guidance pertaining to the disclosure provision allows states to withhold disclosure of information about any case simply because it could cause harm or embarrassment to any person in the family, including the perpetrator of the abuse.

Harfeld admitted that the question of who has a legitimate expectation of privacy in these cases is an important consideration for the Commission. Although it might pertain to the victim, siblings, caseworkers, and some others, confidentiality provisions should not be so broad as to protect the feelings of the person who killed or nearly killed the child.

In 2015, the Children's Advocacy Institute published *Shame on U.S.—Failings by All Three Branches of Our Federal Government Leave Abused and Neglected Children Vulnerable to Further Harm*. The report outlines how federal child welfare laws are weak and inadequately funded, details the nearly invisible role that ACF has played in oversight and enforcement, and discusses the disturbing trend

within the judiciary to decline standing to petitioners seeking to enforce their rights under these statutes. The report concludes with a list of concrete recommendations for each branch of government to remedy some of the worst problems.

Harfeld ended by offering three recommendations for the Commission:

- Amend CAPTA. During the next reauthorization of CAPTA, the language related to public disclosure of child abuse fatalities and near fatalities needs to be clarified and strengthened significantly, and adequate funding should be provided to states so that they can meaningfully execute those changes.
- Specify more robust oversight, evaluation, and enforcement across the board, including closer congressional oversight at ACF.
    - This should include publicly available quarterly status updates through the interagency workgroup or another body. If ACF does not fulfill its role in oversight and enforcement, the agency should face consequences, including sanctions, or perhaps be subject to congressional oversight hearings.
    - ACF must actually enforce CAPTA and title IV-E requirements. Amendments to CAPTA and titles IV-B and IV-E must include clear provisions regarding consequences such as sanctions and penalties on states that fail to comply.
    - The Child and Family Services Reviews (CFSRs) must be strengthened and conducted more frequently, and they should evaluate a more comprehensive scope of measures related to fatal and near-fatal child abuse. States should experience meaningful consequences when they are not compliant, and Program Improvement Plans required of failing states must require actual compliance with the law and not a relaxed set of benchmarks.
    - NCANDS must be utilized. As already proposed by this Commission, NCANDS must be made mandatory for it to be meaningful, with expanded measures, standardized definitions, and penalties for nonreporting.
    - CAPTA and titles IV-B and IV-E must explicitly recognize a private right of action that would ensure that courts can continue to serve as a critical avenue to pursue justice for aggrieved parties when states fail to comply with the law.
- Align funding with the Commission's recommendations. Research from the CDC indicates that the total lifetime economic burden of one year of new cases of maltreatment is as much as $585 billion. Although waivers have produced some exciting innovations and results, they are not a cure-all.

A system with greater accountability and transparency will better serve the interests of the public, the child welfare community, and the children at stake, and it will inevitably lead to safer children and fewer fatalities.

Kathleen Noonan, PolicyLab, The Children's Hospital of Philadelphia

Kathleen Noonan, an attorney involved in child welfare mediation and currently with the PolicyLab at the Children's Hospital of Philadelphia, gave her presentation via telephone. She focused on her work with consent decrees, also called class action cases. She described class action cases as having the following characteristics:

- Most class action cases involve children in foster care. Generally, there is a set of named plaintiffs, representing typical injuries in a system, but the class action suit usually ends up involving all of the children in the system.
- The cases typically focus on permanency, so they can serve as an accountability tool.
- These cases are generally just against the child welfare agency. Occasionally, agency partners might be involved; sometimes Medicaid funding is at stake.
- These cases never view child abuse and neglect as a public health issue.
- In the past, these cases rarely resulted in better systems. They just resulted in systems being in litigation for a lot longer.
- More recently, consent decrees have afforded more flexibility.

Approximately half the states have either just gotten out of a consent decree or currently have a case against them, or they are under settlement agreement. These cases are used regularly by plaintiffs as a way to force the systems to perform better. Utah's consent decree was different in that it allowed the state to make system changes that resulted in good data and transparency, and they were permitted to make modifications without returning to court.

Noonan suggested that the field of child welfare needs something similar to the mortality/morbidity conferences that hospitals have, where there is discussion about reform processes. Currently, there are cases where child welfare agencies just want to avoid lawsuits, but there are no mechanisms to discuss making the systems better. The consent decree process does not include stakeholders outside of the agency and the plaintiff's lawyer. There should be a way to figure out how to bring all voices into the planning process around consent decrees and settlement.

Commissioner Discussion

The following points emerged during the discussion following the panel presentation:

- Most consent decree cases involve constitutional deprivation. There is rarely a consent decree case that involves accusing the state of not providing adequate protection to children (i.e., by removing a child and placing the child in foster care) because the suit would have to show that the state was so reckless that it violated the child's constitutional right to be protected.
- CAPTA currently requires that children in foster care be represented by someone with training, but it does not specify that they be represented by attorneys.
- Stakeholders (families and foster families) need to be involved in the consent decrees and what results from those cases.
- Harfeld's organizations put together a model CAPTA public disclosure policy with 12 elements, and she will provide the policy to CECANF staff. Some of these elements include the following:
    - Every state's policy has to be codified in statute.
    - States would have to collect a specific list of information for each fatality and would be required to go to court for exemptions.
- The CFSRs have not made the full shift to results-oriented accountability.
- Harfeld's organization has proposed making a legislative tie-in between titles IV-E and IV-B funding and CAPTA so that states would know that their IV-E and IV-B money is at risk if they did not fulfill CAPTA requirements regarding child abuse fatalities and near fatalities.

- There is not necessarily evidence to show that accountability related to fines is successful in reducing fatalities. It is not clear that states know how to make the necessary changes to reduce child fatalities, so fining them will not change that.

Strengthening Child Safety Through Partnerships With Health: ***Panel Presentation***

Two presenters from Wisconsin talked about partnerships between child welfare and medical or health services in the state.

Mark Lyday, Director, Child Advocacy and Protection Services, Children's Hospital of Wisconsin

Mark Lyday, who directs the Child Advocacy and Protection Services (CAPS) program at the Children's Hospital of Wisconsin, spoke about how the program focuses on eliminating child abuse and neglect. CAPS actually includes 10 programs:

- Seven child advocacy centers across Wisconsin
- Two medical satellites to provide on-site medical work for outside child advocacy centers
- One large inpatient-based child abuse pediatrics consultation program

Altogether, those 10 programs evaluate about 7,000 Wisconsin children annually.

Lyday described the creation of a statewide program, the Wisconsin Child Abuse Network (WI CAN):

- WI CAN addresses (1) the lack of medical expertise in child welfare workers and law enforcement when working with medical or health personnel and (2) the lack of understanding by medical personnel of the child welfare and law enforcement systems.
- WI CAN is a public/private partnership that involves state agencies, nonprofit community-based organizations, statewide professional associations, and state medical universities and children's hospitals.
- These partner organizations feed down into advisory boards, a leadership team, and focus groups and data, which, in turn, feed educational initiatives, capacity building, partnership development, and evaluation and outcomes.
- Thus far, the focus has been on multidisciplinary education, and staff held 22 webinars in 2014 with 676 attendees from 106 different agencies.

Lyday discussed a recent webinar topic: "sentinel" bruises or injuries and whether these precede more serious injuries in infants. By looking at data from 2008 and 2009 on sentinel injuries in infants who ultimately had major head traumas, it was discovered that a sentinel injury had been noted for 25 percent of the infants before major trauma had occurred. For instance, a child may have had a small bruise on the abdomen or a scrape on the face, and these sorts of injuries preceded more serious injuries that ended up happening days, weeks, or months later.

In order to make these findings known to the field, WI CAN held a webinar. Since the webinar, CAPS has received more requests for consultations on infants with these small sentinel injuries. CPS agencies and police departments may investigate more thoroughly into the family situation, and there are many examples of underlying dysfunction and safety threats uncovered because of those small, seemingly insignificant, injuries.

Lyday described the child advocacy center protocol in Milwaukee, which uses a multidisciplinary Child Abuse Review Team (CART) to maximize child safety and minimize revictimization. Advantages include the following:

- Medical exams by competent experts
- Good collaboration and information sharing among agencies
- Timely collection of evidence
- Good forensic interviews
- Advocates and mental health providers who are involved with the case early in the process

CART partners include the public schools, the public health departments, Wraparound Milwaukee (a mental health agency), and the community domestic violence agency. Weekly and monthly case reviews are performed according to established criteria. Teams may also meet on an emergency basis. The weekly and monthly case reviews feed information to the executive team.

CART developed two screen-out programs to address child abuse and neglect cases involving noncaregivers and cases screened out by CPS. Teams review cases screened out by CPS with the goal of reaching out to the families to provide resources and to initiate a multidisciplinary response. This can involve a number of additional steps:

- Additional review of CPS reports
- Possibly going back to the agency and recommending that the case be screened in
- Outreach to families as a preventive measure
- Working with police departments and advocacy agencies to develop a multidisciplinary response

Data from the Eau Claire program that reviewed 400 screened-out cases showed that recommendations to go back and screen in the case were made in fewer than 2 percent of cases (involving about eight children). When the teams reached out to families whose cases had been screened out, almost 60 percent of those families were receptive to ongoing contact with the child advocacy center, advocates, and multidisciplinary teams.

Lyday also described a second WI CAN program in Milwaukee, which involves a partnership with the domestic violence agency. Studies show that there is a co-occurrence of child abuse and domestic violence between 40 percent and 70 percent of the time, so the same families often need both types of services. In addition, staff experience had been that children were being badly harmed and, at times, killed in domestic violence situations. The partnership program is going to operate out of a new building currently under construction that will house the following groups:

- Family justice center
- Domestic violence shelter
- Child advocacy center
- Law enforcement
- Child welfare
- District attorney's office
- The entire sensitive crimes division of the Milwaukee Police Department

- Mental health agency

This will be a laboratory for collaboration and experimentation, and the focus will be on addressing families' issues early—before they reach crisis status.

Lyday closed by asking the Commission to consider 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.

Cynthia Johnson, Director/Health Officer, Kenosha County Division of Health

Cynthia Johnson, from the Kenosha County Division of Health, discussed prevention of child abuse fatalities in her county. The county has three death review teams—for child deaths, fetal deaths, and adult deaths. They review and study death data in order to determine what works to prevent these types of deaths.

Johnson discussed adverse childhood experiences (ACEs), which is a way to quantify the number of stressors in an individual's life and how they contribute to outcomes or poor health. A greater number of ACEs can potentially lead to early death but also to maladaptive behaviors.

In Kenosha County, the Division of Health has been addressing family dysfunction and maladaptive behaviors with several evidence-based home visiting programs:

- The Nurse-Family Partnership program is for first-time mothers with a high number of ACEs who may have learned maladaptive behaviors in response to these stressors. The county receives funding from the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) federal program. The county also receives a return on the investment made through the federal dollars they recoup through Medicaid or prenatal care coordination. The first graduates of the program completed it last year, and there are currently 115 families in the program, six registered nurses, and one nurse supervisor.
- Parents as Teachers is a program designed to provide positive parenting skills for mothers having a second child. It is both prenatal and perinatal and focuses on safety measures, such as having appropriate car seats and cribs. The program helps mothers develop their own personal reproductive life plan that includes birth spacing. Home visitors also discuss education and employment. Mental health services are offered so that mothers can begin to address the effects of their ACEs. Visitors discuss positive parenting skills and how to promote self-efficacy and school readiness in children.

Mothers are screened for depression and stress using several different measures, and their ACEs are noted. Many referrals come from the federal Women, Infants and Children (WIC) program.

These are 2-year programs, so they require a long-term commitment. The length of the program allows trust to be built between the mothers and nurses. These programs also have had low no-show rates.

Although the program is only 2 years old, the county is already seeing a decrease in the African-American infant mortality rate, which was 24 percent in 2012 and has dropped to 12 percent. Other positive results from the first cohort include increased rates of on-time graduation, decreased poverty, and a decrease in the number of single parents.

Johnson had the following recommendations:

- Expand MIECHV throughout the state and potentially nationally.
- Look at tax incentives for impoverished citizens that might support marriage, work skills, graduation, teen parents who remain in their parents' home, child care, transportation, and returning to work.

Commissioner Discussion

The following points were made during the brief session that followed the presentations from Lyday and Johnson:

- It might be possible to create a "carve-out" for MIECHV funding to provide home visiting services to young women having a baby in state custody (e.g., juvenile justice or child welfare).
- The improvement in infant mortality rate in Kenosha County aligns well with the introduction of the Nurse Family Partnership home visiting program.

Wisconsin Frontline Staff: *Panel Presentation*

Four representatives from various levels of child welfare work in Wisconsin presented on the topic of Wisconsin's safety protocols.

Kirk Mayer, Initial Assessment Specialist, Bureau of Milwaukee Child Welfare

Kirk Mayer, an initial assessment specialist with the Bureau of Milwaukee Child Welfare (BMCW) described his experience of being a child welfare worker on the front lines with children and parents. His job is to gather information to make child safety determinations by following state standards. The process generally follows the following sequence:

- Contacting the reporter of the allegations to gather additional information
- Meeting with the alleged victim, preferably before the child has been influenced by others
- Meeting with any other children that reside in the home
- Meeting with the nonmaltreating parent, if there is one, followed by the maltreating parent
- Speaking with collateral sources to gather additional information

Mayer noted that one of the most important skills for a worker is the ability to engage with others in order to gather additional information. At each interview, the worker must consider present and impending danger to ensure child safety. Information regarding parenting strengths and weaknesses is gathered to assess caregivers' general functioning and their ability to parent. While the incident of maltreatment is addressed with families, the main focus is on gathering information to complete a comprehensive assessment in seven areas:

- Maltreatment

- Surrounding circumstances
- Child functioning
- Adult functioning
- Parenting practices
- Disciplinary approaches
- Family function

According to Mayer, the assessment helps the worker identify and address any diminished parental protective capacities to ensure child safety going forward. The worker is also responsible for conveying pertinent information to a supervisor.

Once a negative family condition has been identified, it is subjected to the agency's danger threshold analysis, which means that the observable family condition is measured against four characteristics: out of control, not managed, will remain active now or in the near future, and will have a severe impact on the child.

All four characteristics must be present for a negative family condition to move from risk to danger. Also taken into account is the vulnerability of each child in the home to the condition. In circumstances of *present danger*, a protective plan is put in place while allowing time to gather additional information to better assess the family. When *impending danger* is identified, a safety plan must be implemented to control any danger threats. This can consist of an in-home family-managed plan with agency oversight, an agency-managed in-home plan, or an out-of-home plan.

Mayer noted that one of the challenges for workers occurs when a negative family condition has been identified but does not cross the danger threshold, so the agency cannot take action. These risk cases are often offered community resources, and the family can opt to use them or not. A strength of this model is that it provides structure and guidance in decision-making.

Advantages of this safety decision-making model include the following:

- It provides a strong foundation of knowledge through the completion of the comprehensive family assessments.
- The threshold criteria provides a guideline to determine if any danger threat exists.
- It allows workers to make safety decisions with more confidence.

Tara Muender, Initial Assessment Supervisor, BMCW

The second presenter was Tara Muender, an initial assessment training supervisor for BMCW, who discussed the ways that the Milwaukee agency prepares workers to conduct family assessments and make safety decisions about children.

Wisconsin conducts safety assessments using a modified version of the safety intervention model created by ACTION for Child Protection. This safety decision-making model allows for the identification of both present and impending danger threats. The model is dependent on the worker's ability to gather sufficient information about families. Having that information results in an objective and descriptive picture of how the family functions on a routine basis, including information about family functioning, child functioning, and caregiver functioning and both the strengths and concerns within families.

Muender stated that workers should remain neutral and objective when collecting information in order to prevent worker bias and premature decision-making. She noted that the greatest challenge for workers and supervisors is in making the determination of foreseeable or impending danger. This requires conscious, deliberate, and extensive efforts to understand the complete family dynamic. That is why information collection efforts that focus solely on the alleged maltreatment—incident-focused assessments or passive information collection—can result in the worker missing the impending danger. As a trainer, Muender emphasizes to workers the importance of thorough information collection and the use of critical thinking skills in the field.

Muender noted that this model has certain requirements for supervisors:

- To ask workers questions around all areas of family functioning to ensure that workers keep an open mind and are digging deeper to fully understand each condition
- To learn about each worker's strengths, struggles, and biases in order to ensure workers are not missing key information
- To help workers enhance their professional knowledge and skills

Wisconsin worked with ACTION for Child Protection to implement an intensive training program called Supervising Safety Decision-Making (SSDM) to improve supervisor competence and confidence. The SSDM training focuses on both present and impending danger over two sessions, breaking down the safety decision-making model to ensure understanding of the material and to give participants the language and methods necessary for explaining the model to workers.

Most supervisors at the BMCW have participated in the SSDM training, and the agency culture has started to shift. Supervisors have become more consistent in conversations with workers, and agency staff at all levels hold each other accountable for fidelity to the safety decision-making model.

Safety assessment continues throughout casework, in association with case plans, service participation, and case management:

- Safety assessment during ongoing CPS focuses on managing existing safety plans.
- The assessment then shifts to consider what kind of progress is being made to enhance caregiver protective capacities and if or how conditions are changing at home.
- Safety assessment at case closure consists of determining whether impending danger threats still exist and the sufficiency of caregiver protective capacities to shield the child from danger.

In summary, Wisconsin's safety decision-making model provides a systematic approach that is applied consistently for all of the families that come in contact with CPS agencies. The decision-making model guides decisions about which families warrant an initial assessment and subsequently may need ongoing intervention services. Following the model results in a higher degree of accuracy for decision-making.

Kelly Oleson, Youth Services Manager, Adams County

Kelly Oleson, the Children and Family Services Manager for Adams County, Wisconsin, Health and Human Services, presented on the training program that she completed to enhance safety decision-making.

Wisconsin worked with ACTION for Child Protection and several other states to develop a safety decision-makers curriculum for supervisors. The program was modified to be specific to Wisconsin and was renamed Supervising Safety. The local modification included the following:

- A focus on the complex analytic process of safety decision-making and developing the habit of thought that supports consistent rigorous practice
- The integration of Wisconsin practice standards, the eWiSACWIS case management system, and job tools
- A format that breaks the program into modules so that the schedule is responsive to the demands on supervisors' time and allows for the implementation of agency change in one area of practice before moving on to the next
- A multifaceted approach that includes face-to-face seminars, coaching, homework assignments, and peer-to-peer coaching

Supervising Safety builds an engaging environment that invites participants to examine their own understanding of complex safety concepts, past decision-making, and practice across their agencies to support organizational change.

DCF and the Wisconsin Child Welfare Professional Development System partnered to work on statewide implantation. A group of 24 supervisors piloted the program in 2014. By the end of 2015, 117 participants from 48 counties, one tribe, and DCF will have completed the first module, which focuses on present-danger threats. The plan is to focus next year on the second module related to impending-danger threats.

Oleson described the experience of implementing Supervising Safety in Adams County, an extremely rural community that has experienced increases in heroin use, child poverty, and a lack of affordable housing. The county also struggles with shortages of transportation, mental health resources, and child care.

Oleson was able to complete the Supervising Safety curriculum in 11 months and to incorporate this analysis of safety into practice in Adams County. She noted a number of positive outcomes:

- Workers are better able to identify present danger when child abuse reports are received.
- There has been a 50-percent increase in reports being responded to since implementation.
- As a supervisor, Oleson feels more confident in her decision-making, and the workers she supervises feel more confident in making safety plans for children.
- Social workers are completing better assessments of families by gathering sufficient information to inform their decision-making.
- Workers are more consistent in their evaluation and analysis of safety. For instance, cases are reviewed at a weekly staff meeting, and impending-danger threats are identified as part of the case consultation.
- Workers present safety analysis to staff, and this has supported consistency in the application of safety standards.
- Social workers' increased confidence in their decision-making has resulted in more thorough protective planning with families, so that more families stay intact and there have been fewer removals into out-of-home care.

- Safety plans are better structured and easier to understand, and safety services are more focused and result in more positive outcomes without rereferrals.
- Communication with families has improved.

Adams County increased staffing by adding three full-time social workers and a supervisor position in 2014. These changes resulted in reduced caseloads and increased opportunities for individual supervision.

An initial analysis indicated that Supervising Safety, along with the staffing and cultural shift in Adams County, contributed to the following trends:

- Children spending less time in out-of-home care
- Fewer children being removed from the home without implementing a protective plan first
- A shift from placement costs to preventive costs and an increase in the number of families served for the same cost
- Better identification of families early in the process
- Less focus on substantiation

The county is tentatively anticipating a reduction in out-of-home care costs by nearly $200,000 this year compared to last.

Oleson concluded that her participation in Supervising Safety impacted the overall practice in Adams County around child welfare and resulted in a paradigm shift from constant crisis to a clarified focus on safety.

Julie Ahnen, CPS Services Manager, Dane County

Julie Ahnen, the CPS manager for Dane County, was the fourth and final panelist. She discussed her experience with the Supervising Safety curriculum and its impact on a large, more urban county in Wisconsin.

Ahnen noted that the Supervising Safety training has two major advantages:

- It solidifies the central role that safety decision-making plays in CPS involvement in families' lives.
- It provides supervisors with a better understanding of the fact that safety decisions, substantiation decisions, and decisions around petitioning the court for jurisdiction are distinct from one another. In the past, workers and supervisors might spend too much time anticipating whether or not there was enough evidence to substantiate or whether or not the legal counsel would accept a petition. These concerns can take the focus off of safety decision-making.

Supervisors have sometimes been challenged by supporting decisions based on workers' verbal descriptions of injuries, conditions, or circumstances. The county has partially addressed this issue by providing all CPS staff with iPads that allow workers to take pictures of injuries or living conditions and email them directly to the supervisor.

Ahnen also listed a number of ways that Dane County builds redundancy and other safety measures into the review process:

- In response to an infant fatality in 2007, the county agency instituted a practice requiring that two supervisors review any report involving a child under the age of 2 years for a final screening decision. In cases in which there is a disagreement, the response with the highest level of urgency is adopted.
- Ahnen reviews emergency response cases on an almost daily basis. Her recent training in Supervising Safety has led her to include an assessment of the quality of the information gathered and the justification of safety decisions.
- Ahnen also reviews a number of the screened-out reports every month.
- The internal case review process for all out-of-home cases recently changed to focus on documentation in WiSACWIS. This ensures that workers and supervisors are regularly discussing and updating documentation around safety, family interaction, and child and adult functioning.
- Ahnen serves on Dane County's fetal and infant mortality review team. The team is currently focusing on infant deaths related to unsafe sleep conditions.
- Ahnen reviews every child fatality case and every case that is reported to the state as a serious or egregious incident. Most of these cases involve young children under the age of 4 years, and there are elements of domestic violence in many of these cases, as well as isolation of these families from natural and community supports. These isolated families are sometimes known to CPS, but the conditions or circumstances that are reported are often not enough to warrant formal agency involvement.

Ahnen recommended that funding be available for a community-response approach to families who are reported for possible child maltreatment but whose circumstances do not warrant substantiation or child welfare agency involvement.

Commissioner Discussion

The following points were made during the question-and-answer session that followed the panelists' presentations:

- In cases where the safety decision-making training was implemented and then there was a child fatality, the review indicated that there was a failure to collect complete information from or about the family.
- It might be beneficial for workers to have medical or law enforcement experts as part of the investigative team when they visit families to investigate reports of abuse or neglect.

Commission Deliberations: Public Disclosure

The Commissioners discussed what kind of recommendation to make regarding public disclosure of information after a child fatality due to abuse or neglect, given that there are arguments for and against complete disclosure:

- Arguments against full disclosure cite the need to protect the family, especially siblings, and the need to not interfere with any criminal investigation.
- Those in favor of full disclosure cite the need to learn from what happened and to bring to light any problems as well as the right of the public to know.

Commission discussion focused on the following questions:

- What is the appropriate balance between family privacy rights and the public's need to know, particularly regarding system accountability? Responses included the following:
    - Consideration should be given to the fact that sometimes individual workers are tried in the press, and this may pose a barrier to child welfare workers doing their jobs.
    - Publishing all the details in the newspaper does not necessarily translate into accountability for the system.
    - Publicity about this issue may encourage politicians to take action.
    - Publicity about fatalities should include action items for the public, such as how to become a foster parent and how and when to report child abuse.
    - Any public report should be made after a slow and careful investigation.
    - Information about the victim and family should be generic to protect their identities.
    - Even when the child welfare agency cannot release information, the police, family members, or others often release details. In these cases, a "no comment" response from the child welfare agency just looks like the agency is trying to cover up.
    - The photos of children who are victims make an impression on the public.
- Does this Commission have an opinion about the CAPTA requirements for states to disclose details after a child maltreatment death (e.g., requirements to disclose the gender of the child, the details of the death or near death, etc.)? Replies included the following:
    - There should be a way for child welfare to help the public when these stories are published, for instance, by letting the public know that there are resources for them if they are experiencing stressful parenting.

- Courts and agencies can provide generic information to the press and let them know that a case is being investigated without giving the victim's name. Also, the press should be invited in at times when there has not been a tragedy so that they can see what the routine work is.
- Perhaps the best thing the Commission can do is recommend best practices in public disclosure.
- The Children's Bureau is actively seeking input on the CAPTA requirements around public disclosure.
- One way to provide public disclosure is the way that Wisconsin described, which is to provide just limited information at first and then more information as the case is investigated.
- The Commission could suggest what basic information should be disclosed after every fatality.
- CAPTA's requirements for public disclosure could be enhanced to require reports of how systemic issues will change to ensure that there is no repeat of these circumstances—that is, reforms that the agency will make as a result of this child's death.
- The Commission could recommend the standardization of all child fatality reports, so that there would be at least minimal information provided for all.

THURSDAY, JULY 16, 2015

Chairman Sanders opened the second day of the meeting, noting that there would be one local speaker, followed by Commissioner deliberations.

Wisconsin's Strategies for Preventing Child Abuse and Neglect Fatalities: *Eloise Anderson*, *Secretary*, *Wisconsin DCF*

Eloise Anderson, Wisconsin's Secretary of the Department of Children and Families (DCF), spoke about the state's prevention strategies. Secretary Anderson named a number of risk factors for child abuse and neglect fatalities identified in Wisconsin, including the following:

- Poverty
- Single parenthood and nonbiological caregivers (boyfriends)
- Adolescent parents, especially those who grow up in the child welfare system
- Substance abuse
- Mental health issues
- Children under 4 years of age
- Families with a large number of children
- Children with special needs
- Social isolation
- Domestic violence
- High levels of community violence

- Multiple risk factors

Since 2013, Wisconsin has had about 20 child fatalities; most of the parents in these cases were mothers, and most of the deaths were caused by neglect. In the cases of physical abuse, most of the perpetrators were boyfriends or partners, not the biological parent. Most of the children were under the age of 5 years.

Secretary Anderson offered a number of recommendations:

- Pay special attention to children under 5, who tend to be invisible because they are not yet in school.
- Train child care providers to be more aware of children's issues.
- Make child welfare more family centered.
- Work with nonbiological parents to reduce risk of harm to children.
- Address neglect.

Secretary Anderson noted that Wisconsin has three strategies for preventing child abuse and neglect fatalities:

- Providing early intervention
- Strengthening and supporting families
- Building community connections with families to address isolation

Wisconsin has a number of programs that aim to keep children safe:

- Home visiting—One of Wisconsin's major prevention programs is home visiting, which is targeted for high-risk communities. Parents volunteer to be part of the program, which helps them work on parenting skills. This is especially important for parents who grew up in families where their own parents did not serve as good role models. There is also a component for men, which involves them with a specialist on good fathering skills.
- Postreunification services—Wisconsin also provides postreunification services through a program that extends for 12 months after children return home. It addresses family stressors and provides services to ensure that families can achieve stability and safety for the children.
- Community response program—This program provides case management, home visiting, and financial supports. It helps the family figure out their goals.
- Connection Counts—This program connects community leaders with people who need guidance so that they can be referred to community services.
- Families and Schools Together—FAST support parents in raising their children, and it teaches parents to play with their children.

Secretary Anderson noted that it would be helpful to have more flexibility in the state's title IV-E funding so that the state could better support prevention.

Commissioner Discussion

The following points were made during questions and answers between the Commissioners and Secretary Anderson:

- In order to address the issue of the nonbiological father figure in the home, there should be child development education in prisons; prisons could let child welfare agencies know where the men are living; there could be more home visiting; and men could receive child care training and advice as part of job training (as women do).
- The focus on fathers in Wisconsin has resulted in more fathers getting custody of children, more opportunities for paternal families to be kinship caregivers, and more dads stepping up to support their children.
- Child welfare agencies may be the best agencies to lead the community in preventing child abuse and neglect fatalities, but they need to hire people with the right leadership skills in order to take on that leadership role.

Commissioner Deliberations: Policy Subcommittee

The subcommittee findings and the subsequent discussion made the following points:

- The Commission's final report should emphasize that child safety is paramount.
- Organizing principles around policy include clarification and understanding, accountability, effectiveness, and efficiency.
- The data on child fatalities due to abuse and neglect are bad, which is worse than having no data at all. Data need to be improved and to include more details.
- There needs to be someone at a high level in the federal government who is responsible for this issue. One option would be to elevate the level of the Children's Bureau.
- There is enormous variation among the states in how much they protect children and in how safe children are.
- There needs to be a mechanism in place for states to share information in order to protect children across state lines.
- Collection of data needs to be embedded in a quality improvement process.
- More attention might be paid to reports that are screened out, especially if they concern children ages 3 and under.

Commissioner Deliberations: American Indian/Alaska Native Subcommittee

The Subcommittee members explained how they pulled together the recommendations that they presented. They identified experts, invited them to Subcommittee phone meetings, and then invited a number of the experts to present at the public meeting in Arizona. The recommendations include 27 made at the public meeting, as well as a supplement of 10 additional recommendations based on testimony from the July 15 meeting. The two sets of recommendations were distributed to Commissioners and posted on the website. The following points were made during discussion:

- The themes that run through the recommendations are funding, services, and collaboration to be creative about how the services are provided.
- There is a major emphasis on respecting the sovereignty of tribes.
- Collaboration involves states and the federal government.
- Indian issues should probably be discussed in a separate chapter in the final report because there are so many issues unique to Indian Country. The uniqueness stems from the sovereign

nature of the tribes and from the treaties between the tribes and the U.S. federal government that require the United States to do things like fund CPS for tribes.

- At a minimum, tribes should receive from the federal government what states receive.
- Some of the themes for these recommendations include intergenerational trauma, the role of the father, and the suicide trend for adolescents.
- Tribes often lack the infrastructure to gather data on child welfare.
- It is difficult for tribes to qualify for title IV-E funding because of some of the requirements, including those pertaining to providing a match.
- It is difficult to find social workers who are willing to work in some of the isolated areas where tribes live.

Commissioner Deliberations: Final Report

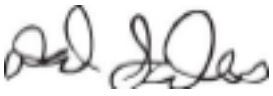
The Commissioners then discussed the handout labeled "Emerging Themes and Recommendations—Draft 7.3," which staff had drafted based on meetings, site visits, and research since the inception of the Commission. The following points emerged during the discussion of the document:

- The final report needs to be clear, not in the weeds, and tell a story and present a vision for the future, noting where things might have been done differently in specific instances.
- Themes should be labeled "Findings."
- The way it is currently organized results in a broken-up document. There needs to be a headline that is a central organizing principle.
- The report needs to give the message that there is hope for resolving child fatalities.
- The report needs to point out what does work—like safe sleep programs.
- Perhaps the Commission should recommend a standard of care for child welfare.

The Commissioners discussed some next steps in the process of discussing the report.

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.



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David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities
11/23/2015