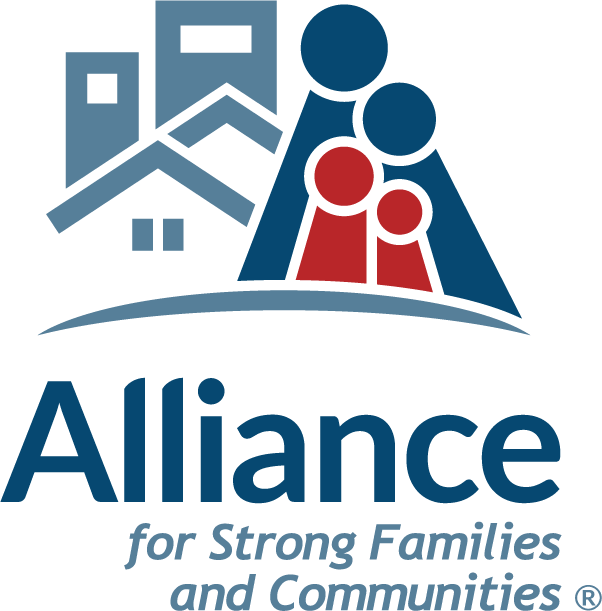


Within Our Reach:

Advancing a National Strategy to Eliminate Child Abuse and Neglect Fatalities

Stakeholder

Toolkit

Developed by

Within Our Reach

February 2017

**A MESSAGE FROM AMY TEMPLEMAN**

**In March 2016,** the Commission to Eliminate Child Abuse and Neglect Fatalities released its [final report](https://cybercemetery.unt.edu/archive/cecanf/20160323195035/http://eliminatechildabusefatalities.sites.usa.gov/), “Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities.” A culmination of a two-year effort to study, review, and address child abuse and neglect fatalities, the report represents a shared vision among a broad range of stakeholders of how we can save lives and reform the child welfare system for the 21st century.

This is an issue that has frustrated and confounded generations of policymakers, child protection officials and government leaders – but one that we believe is solvable if we as a nation can harness greater leadership and accountability, better data and research and a multi-disciplinary approach to saving lives.

In many ways, the real work began after the report was issued – by taking the Commission’s recommendations and turning them into policy and practice at the federal, state, tribal and local level. This toolkit is designed to assist stakeholders, including policymakers, child welfare leaders, child advocates and more, in understanding, communicating and implementing the recommendations of the Commission.

To support these efforts, The Alliance for Strong Families and Communities under the leadership of former Commissioner Susan Dreyfus has established a new office called Within Our Reach, funded by Casey Family Programs.

This office will be the key organizer to promote the Commission's work through a spirit of shared ownership and collaboration with many partners and stakeholders. For more information on how you can support the goals and recommendations of the Commission, I invite you to contact me at:

Amy Templeman   
Director, Within Our Reach   
Alliance for Strong Families and Communities   
1825 K Street, NW, Suite 600   
Washington, DC 20006   
[atempleman@alliance1.org](mailto:atempleman@alliance1.org)

202-429-0064

**Sincerely,**

**Amy Templeman**

Director, Within Our Reach

**TABLE OF CONTENTS**

What Stakeholders Can Do…………………………………………………………………………………………....3

What CPS Agencies Can Do……………………………………………………………………………….……….…..4

Key Dates….. ………………………………………………………………………………………………………….…..….6

Fact Sheet……….………………………………………………………………………………………………………..……7

Press Release Template………………………………..………………………………………………………….…..9

Op-Ed Template…………………………………………………………………………………………………….………11

Letter-to-the-Editor Template……………………………………………………………………………….…….13

Social Media Toolkit……………………………………………………………………………………………………..14

Talking points/FAQ……………………………………………………………………………………………………….15

PowerPoint Presentation……………………………………………………………………………………………….21

Federal Legislation Impacting Child Welfare….………………….……………………………….………22

Sample Statement in Support of Recommendations…………………………………………………….23

Sample Policy Statement………………………………………………………………………………………………24

Reference List of CECANF Recommendations………………………………………………………….…..28

**WHAT STAKEHOLDERS CAN DO**

This toolkit provides ideas for stakeholder engagement around the goals, strategies and recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) Report: “Within our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities.” Suggested communications and advocacy activities to promote the CECANF recommendations include:

**Communications Outreach**

Activities to help build awareness for the recommendations and their potential impact include:

1. Issue a press release from your organization highlighting one or more key policies or recommendations that relate to what your organization does. Use the list of key dates to tie the release to a relevant week/month. Share it broadly with your media contacts. Include a spokesperson contact for media to reach you. (See Key Dates/Press Release Template).
2. Issue an Opinion-Editorial in support of a key recommendation with your byline. (See Op-Ed Template).
3. Respond to a local news story with a Letter-to-the-Editor that highlights a key recommendation. (See Letter-to-the-Editor Template).
4. Use your social media platforms to post/tweet about key recommendations (See Social Media Toolkit).
5. Present at a conference or stakeholder meeting about the recommendations that relate to your constituency. (See Fact Sheet/Talking Points/FAQs/ PowerPoint Presentation).

**Advocacy Outreach**

Activities to help build support for advocacy, policy change and legislative action include:

1. Issue a Statement highlighting recommendations, and policy and practice changes related to the report. (See Sample Statement in Support of Recommendations).
2. Encourage your constituency to write a letter to Congressional Leaders and/or State Government Leaders encouraging their support for key legislative actions/policy changes. (See Federal Legislation Impacting Child Welfare/Sample Legislative Letter).

Some specific messaging and calls to action for community outreach include:

1. Educate and engage community members about resources such as the Nurse-Family Partnership.
2. Share success stories and best practices from your community.
3. Highlight the importance of prevention in combating child maltreatment and fatalities.

**WHAT CPS AGENCIES CAN DO**

The Commission’s call for widespread reform of the child welfare system and a public health approach cannot happen overnight. CPS cannot make these changes alone. However, there are steps that CPS agencies can take *today* to make children safer. These steps will not only prevent fatalities, but will also help build critical infrastructure and the body of knowledge needed to build a new 21st Century child welfare system.

1. **Identify Children At Risk --** CPS agencies should undertake a retrospective review of child abuse and neglect fatalities to help them identify family and systemic circumstances that led to child maltreatment deaths in the past five years. States will then use this information to identify children at highest risk now, and they will develop a fatality prevention plan to prevent similar deaths both now and in the future.
2. **Respond to Children At Risk --** CPS agencies should review current screen-out policies to ensure that all referrals of children under age 3 and repeat referrals receive responses. In addition, investigation policy should be reviewed to ensure that reports for children under age 1 are responded to within 24 hours.
3. **Prioritize Children At Risk --** Children under age 5 and children with prior CPS reports should be prioritized for home visiting programs.
4. **Share Information Across Systems --** CPS agencies should develop a system for cross-notification for allegations of child abuse and neglect with law enforcement, similar to the Electronic Suspected Child Abuse Report System (E-SCARS) in Los Angeles County.
5. **Expand Areas of Review --** Reviewing life-threatening injuries from abuse and neglect is an important part of the picture when it comes to preventing maltreatment fatalities and should be included in the child death review process.
6. **Enhance Standards and Accountability --** Accountability is a critical component for success and is relevant to almost all of our recommendations. A range of providers, including CPS, must work together and hold each other accountable. Mandated reporters, too, should be held to minimum standards and receive quality training.
7. **Address Disproportionality and Quality Services for All --** CPS agencies should ensure that quality services are available to all children and families and that all families are treated equitably. Quality services (i.e., services that are effective, culturally appropriate, and targeted) are needed to support children and their families who are disproportionately represented in child welfare and other child-serving systems. Services other than foster care must be identified and implemented. Particularly in communities disproportionately represented in child welfare and with a higher incidence of child abuse and neglect fatalities, efforts at the federal, state, and local levels need to address quality with the same emphasis as availability and accessibility. Where disproportionality is pervasive, prioritize training of the child welfare workforce, partners, and mandated reporters on the topics of (1) family engagement, development, and strengthening; (2) understanding distinct racial and ethnic cultures and racial and ethnic cultural norms and differences; (3) understanding the historical context of racism; (4) understanding and recognizing biases; and (5) how biases can impact assessment of risk, access to services, and delivery of services.
8. **Strengthen Parenting and Caregiver Services --** CPS agencies should expand the screening of caregivers for elevated risk factors, including toxic stress and social determinants of health, and provide early connections to services. Innovation can be strengthened via public-private partnerships that help to eliminate barriers to accessing early infant mental health services that engage parents in strengthening parenting.
9. **Provide Access to Prevention Focused Services --** CPS agencies should enhance policies to identify partners/contracted resources for medical review and evaluation; case management for access to voluntary home visiting services; and access for families to domestic violence counseling, mental health services, and substance abuse treatment services.
10. **Develop Multidisciplinary Teams for Prevention --** CPS agencies should explore opportunities for the development of multidisciplinary prevention initiatives in partnership with other local agencies such as law enforcement. Share best practices with other CPS agencies.

**KEY DATES**

Throughout the year, stakeholders and communities can participate in activities that broaden awareness around child health and abuse prevention issues. The annual calendar of special days, weeks and months offer year-round opportunities to share information on the Commission and its recommendations. The following highlights key annual observances that reflect the broad work of child welfare, health and safety providers:

January Mental Awareness Month

March Child Life Month

March National Professional Social Work Month

March Brain Injury Awareness Month

April 4-8 National Youth Violence Prevention Week

April 4-10 National Public Health Week

April National Child Abuse Prevention Awareness Month

April Alcohol Awareness Month

April Counseling Awareness Month

April National Minority Health Month

May 1-7 National Children’s Mental Health Awareness Week

May 15-21 National SAMSHA Prevention Week (Mental Health)

May Family Support Month

May Mental Health Month

May Helping American Youth Month

May National Maternal Depression Awareness Month

May National Foster Care Month

June Children’s Awareness Month

July Purposeful Parenting Month

October National Depression & Mental Health Screening Month

October 5 Child Health Day

September Child Passenger Safety Week (2nd week of month)

December Safe Toys and Gifts Month

**FACT SHEET**

**Within Our Reach:**

**A National Strategy to Eliminate Child Abuse and Neglect Fatalities**

The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) was established by the Protect Our Kids Act of 2012 to develop a national strategy and recommendations for reducing child fatalities resulting from abuse and neglect. Beginning in 2014, twelve Commissioners, appointed by the president and Congress, began a two-year process of holding public hearings in 11 jurisdictions to hear from state leaders, local and tribal leaders, child protection and safety staff, advocates, parents, and more.

Key Findings:

* An estimated four to eight children a day, every day, die from abuse and neglect.
* Children who die from abuse and neglect are overwhelmingly young; approximately one-half are less than a year old, and 75 percent are under 3 years of age.
* A call to a child protection hotline is the best predictor of a child’s potential risk of injury death before age 5.
* A number of children who die were not known to child protective services (CPS) but were seen by other professionals (e.g., health care), highlighting the importance of coordinated and multisystem efforts.
* Access to real-time information about families is vital to child protection efforts, but legal and policy barriers prevent this from occurring.
* We do not know the exact number of children who die from abuse and neglect; although we know it is critical to have these data to understand what works.
* We know a lot about what puts children at risk, but there are few promising solutions and only one evidence-based practice shown to reduce fatalities—the Nurse-Family Partnership.

The report outlines a strategy for realigning organizations and communities to protect children at highest risk of fatality from abuse or neglect with CPS playing a critical role in partnership with others. By combining a proactive approach to child safety with a more strategic response, the goal is to make prevention of fatalities from abuse and neglect standard practice.

### Recommendations to save children’s lives today:

1. States should undertake a retrospective review of child abuse and neglect fatalities from the previous five years to identify family and systemic circumstances that led to fatalities. Congress and the administration have significant roles in the implementation and oversight of this recommendation.
2. Every state should review their policies on screening reports of abuse and neglect to ensure that the children most at risk for fatality—those under age 3—receive the appropriate response, and they and their family are prioritized for services, with heightened urgency for those under the age of 1.
3. The administration should lead an initiative to support the sharing of real-time information among key partners such as CPS and law enforcement.
4. State receipt of funding from the Child Abuse Prevention and Treatment Act (CAPTA) should be contingent on existing child death review teams also reviewing life-threatening injuries caused by child maltreatment.
5. All other programs—such as Medicaid and home visiting programs—should be held accountable for ensuring their services are focused on reducing abuse and neglect fatalities.
6. Federal legislation should include a minimum standard designating which professionals should be mandatory reporters of abuse or neglect, and these professionals should receive quality training.

**Recommendations that lay the groundwork for a national strategy:**

1. Elevate the U.S. Department of Health and Human Services’ (HHS’) Children’s Bureau to report directly to the Secretary of HHS.
2. Using information from their review of fatalities, every state should be required to develop and implement a comprehensive state plan to prevent child abuse and neglect fatalities.
3. Congress should conduct joint committee hearings on child safety, provide financial resources to support states, and encourage innovation to reduce fatalities. While all Commissioners agreed that funding is needed to support these efforts, no consensus was achieved on the amount of funds to be provided.
4. Congress should support flexible funding in existing entitlement programs. Some high-cost interventions, such as long-term group care and generic parenting programs, have been demonstrated as less effective. Reinvesting resources might improve outcomes.

Throughout our process, the Commission identified three groups of children who present unique challenges when it comes to preventing child abuse and neglect fatalities: children known to the CPS system today who are at high risk of an abuse or neglect fatality, American Indian/Alaska Native (AI/AN) children for whom little if any data exist, and African American children who die from abuse and neglect at a rate that is two-and-a-half times greater than that of white or Hispanic children. The following are key recommendations offered to Congress, the administration, and state and tribes to address these groups:

1. Analyze data from past fatalities to identify the children who are at greatest risk now.
2. Improve and support data collection about child abuse and neglect fatalities of AI/AN children, and work to improve collaborative jurisdictional responsibility for these children’s safety.
3. Conduct pilot studies of place-based intact family courts in communities with disproportionate numbers of African American child maltreatment fatalities.

**A Public Health Approach to Child Safety**: The Commission’s recommendations reflect a public health approach to child safety that engages a broad spectrum of community agencies and systems to identify, test, and evaluate strategies to prevent harm to children based on three interrelated core components:

1. ***Leadership and Accountability*:**Strong leaders at every level—federal, state, local, and tribal—are needed.
2. ***Decisions Grounded in Better Data and Research***: We need to collect, share, and utilize real-time, accurate data to ground child protection decisions.
3. ***Multidisciplinary Support for Families*:** Everyone has a role. Cross-system prevention and earlier intervention are critical to building and sustaining healthier families and communities.

For a copy of the full report, go to <https://cybercemetery.unt.edu/archive/cecanf/20160323195035/http://eliminatechildabusefatalities.sites.usa.gov/>.

**PRESS RELEASE TEMPLATE**

**For Immediate Release** **Contact:** [Contact Info]

[List Date]

**\*\*\*\*\*PRESS RELEASE \*\*\*\*\***

**[NAME OF ORGANIZATION] SUPPORTS FEDERAL COMMISSION’S EFFORTS TO**

**ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES**

**[CITY, STATE, DATE] –** [List name of organization] announced today its support for the recommendations of the federal Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) in a report released March 2016 to the President and the Congress. The report, entitled: *Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities*, was the culmination of a two-year effort to research and study issues related to child abuse and neglect*.*  CECANF was established by Public Law 112-275 (112th Congress), the Protect Our Kids Act of 2012.

“According to the Commission’s findings, if we as a nation continue on our present course, an estimated 1,500 to 3,000 U.S. children will die from maltreatment next year,” noted [List name of your spokesperson]. “We need to dramatically redesign our approach to child welfare and system with an emphasis on prevention to ensure children and families in crisis receive the supports and interventions they need before a crisis occurs.”

Key findings from the Commission’s report included:

* Children who die from abuse and neglect are overwhelmingly young; approximately one-half are less than a year old, and 75 percent are under 3 years of age.
* A call to a child protection hotline is the best predictor of a child’s potential risk of injury death before age 5.
* A number of children who die were not known to child protective services (CPS) but were seen by other professionals (e.g., health care), highlighting the importance of coordinated and multisystem efforts.
* Access to real-time information about families is vital to child protection efforts, but legal and policy barriers prevent this from occurring.
* We do not know the exact number of children who die from abuse and neglect; although we know it is critical to have these data to understand what works.
* We know a lot about what puts children at risk, but there are few promising solutions and only one evidence-based practice shown to reduce fatalities—the Nurse-Family Partnership.

CECANF’s report outlines a proactive approach to child safety with stronger collaboration among agencies that come into contact with children, more informed decision-making based on better data and tools, and a public health approach that emphasizes prevention. Key recommendations of the Commission include:

* + - * States should undertake a retrospective review of child abuse and neglect fatalities from the previous five years to identify family and systemic circumstances that led to fatalities. Congress and the administration have significant roles in the implementation and oversight of this recommendation.
      * Every state should review their policies on screening reports of abuse and neglect to ensure that the children most at risk for fatality—those under age 3—receive the appropriate response, and they and their family are prioritized for services, with heightened urgency for those under the age of 1.
      * The administration should lead an initiative to support the sharing of real-time information among key partners such as CPS and law enforcement.

The Commission outlined a national strategy for a child welfare system for the 21st century based on a public health approach to child safety. The strategy calls for enhanced leadership and accountability at the federal, state, local and tribal level, better data and research to inform decision-making, and a multi-disciplinary approach to building and sustaining healthier families and communities. Additional recommendations from the Commission that lay the groundwork for systemic reform as outlined in its national strategy include:

1. Using information from their review of fatalities, every state should be required to develop and implement a comprehensive state plan to prevent child abuse and neglect fatalities.
2. Congress should conduct joint committee hearings on child safety, provide financial resources to support states, and encourage innovation to reduce fatalities. While all Commissioners agreed that funding is needed to support these efforts, no consensus was achieved on the amount of funds to be provided.
3. Congress should support flexible funding in existing entitlement programs. Some high-cost interventions, such as long-term group care and generic parenting programs, have been demonstrated as less effective. Reinvesting resources might improve outcomes.

[Paragraph highlighting ways in which your organization plan to support, promote, and put into practice key elements of the Commission’s recommendations.]

***About [Your Organization]***

[Include your boilerplate.]

###

*Media Notes: For more information, contact Amy Templeman, Director, Within Our Reach, Alliance for Strong Families and Communities,* [*atempleman@alliance1.org*](mailto:atempleman@alliance1.org)*, 202-429-0064. For a full copy of the report, go to* [*https://cybercemetery.unt.edu/archive/cecanf/20160323195035/http://eliminatechildabusefatalities.sites.usa.gov/*](https://cybercemetery.unt.edu/archive/cecanf/20160323195035/http://eliminatechildabusefatalities.sites.usa.gov/)*.*

OP-ED TEMPLATE

Within our Reach –

A National Strategy to Eliminate Child Abuse and Neglect Fatalities

Every day, eight children in this country are killed at the hands of their caregivers. Unless we take action, between 1500 and 3000 children will die through abuse or neglect within the next year alone. What can we as a nation do to prevent these tragedies?

The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF), which was established by the Protect Our Kids Act of 2012, released a report earlier this year that outlined a national strategy for reducing child abuse and neglect fatalities.

Informed by two years of comprehensive study and testimony from more than 150 experts and stakeholders, including child welfare commissioners, pediatricians, law enforcement officials, parents and youth served by child protection agencies, the Commission’s recommendation provided a road map for a public health approach that places emphasis on preventing these tragedies before they occur.

That process begins with identifying children most at risk. The Commission identified some of the most common risk factors for children who die from abuse and neglect: 1) they are overwhelmingly young; 50 percent are under age one and 75 percent are under age three; 2) a large proportion of children who die were not known to child protective services (CPS) but were seen by other professionals (e.g., health care), highlighting the importance of coordinated and multisystem efforts; 3) a call to a child protection hotline was the best predictor of a child’s potential risk of injury death before age 5.

The Commission’s report also highlighted the fact that while we know a lot about what puts children at risk, there are few promising solutions and only one evidence-based practice shown to reduce fatalities—the Nurse-Family Partnership, a home visiting program. However by building on the current body of knowledge, including efforts from other industries and from communities that have developed promising approaches to reduce fatalities, the Commission believes we can begin to save children's lives immediately.

By combining a proactive approach to child safety with a more strategic response, the Commission believes that we can make prevention of fatalities from abuse and neglect a standard practice. To accomplish that goal, they asked states to analyze data from past fatalities to identify the children who are at greatest risk right now, then prioritize resources for these children. States and counties should review policies to screen reports of abuse and neglect to ensure that the children most at risk for fatality—those under age three—receive the appropriate response and they and their family are prioritized for service.

There are currently five states that have started this review process: Alaska, Connecticut, Illinois, Maine and Oklahoma.

The Commission also recommended that, when child protection and law enforcement are both investigating a family, they must be able to share potentially life-saving information.

[List your organization] supports these recommendations and [list actions you are taking to put recommendations into practice, i.e. releasing a policy statement or guidance for your constituents around the Commission’s findings].

In the short term, the recommendations can save lives immediately. In the long term, they reflect a public health approach to child safety that engages a broad spectrum of community agencies and systems to identify, test, and evaluate strategies to prevent harm to children. When it comes to the health and safety of our children, we can, and must, do better.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[List author name and affiliation.]**

LETTER-TO-THE-EDITOR TEMPLATE

Editor

[Name of Publication]

[Street]

[City, State Zip]

Dear Editor:

In response to the article [list date and article headline], this is a tragedy that is currently being played out in communities across the nation. In fact, each year, more than 1,500 U.S. children die as a result of abuse and neglect.

That is why President Obama and the Congress charged the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) with developing a national strategy for reducing these tragedies. CECANF released its report earlier this year calling for a public health, preventive-based approach to the issue of child abuse and neglect fatalities.

The issue is complex. Increasingly, we are finding that a lack of communication and data sharing between agencies, including child protective services (CPS), law enforcement, the judiciary, and other local agencies means more children are falling through the cracks.

Child welfare systems cannot address this problem alone. Preventing these tragedies will require a multi-agency process to identify, count, and report on child abuse fatalities with a goal of identifying those children most at risk. By drawing on safety science principles that promote enhanced training, system improvement, interoperability and shared accountability, we can all work together to better protect vulnerable children.

For more information on the Commission, its work and findings, go to: <https://cybercemetery.unt.edu/archive/cecanf/20160323195035/http://eliminatechildabusefatalities.sites.usa.gov/>.

Sincerely,

[Your name]

[Your affiliation]

SOCIAL MEDIA TOOLKIT

# Recommended Social Media Posts

UPLOAD:

If on Twitter: Upload Image A – [**DOWNLOAD HERE**](https://wearerally.box.com/shared/static/l1pe7c7cidov0pdlr750txjv3w97t097.jpg)

If on Facebook: Upload Image B – – [**DOWNLOAD HERE**](https://wearerally.app.box.com/shared/static/pal8jwkjvxth335tv5ypv8auwqtt2tj4.png)

1. Together, we can end child maltreatment fatalities. Read the report and #protectourkids: <http://bit.ly/CECANF>
2. Each year an estimated 1,500-3,000 children die from abuse and neglect. This is preventable. <http://bit.ly/CECANF>
3. Public health and child safety agencies can ensure that the most vulnerable children are seen and supported. <http://bit.ly/CECANF>
4. Child maltreatment fatalities damage communities and our nation. Let's take action. READ: <http://bit.ly/CECANF>
5. We must prioritize innovative solutions to prevent child abuse, not just react to it. READ: <http://bit.ly/CECANF>

# ACCOMPANYING Image Asset

1.  B.

A. Twitter

DOWNLOAD: [CLICK HERE](https://wearerally.box.com/shared/static/l1pe7c7cidov0pdlr750txjv3w97t097.jpg)

Image Description: Headline includes the Commission to Eliminate Child Abuse and Neglect Fatalities logo. The copy reads “Together, we can end child maltreatment fatalities,” in white font against a light blue background. Image includes copy that says “read the report,” referring to a link reading bit.ly/CECANF. There is a hashtag that reads #stopchildmaltreatment. In the background are faded images of smiling children.

B. Facebook

DOWNLOAD: [CLICK HERE](https://wearerally.box.com/shared/static/pal8jwkjvxth335tv5ypv8auwqtt2tj4.png)

Image Description: On the left side is a picture of two smiling children. To the right of them, the copy reads “Together, we can put an end to child maltreatment fatalities,” in blue font against a white background. In the bottom right corner, it reads “learn more: bit.ly/CECANF,” above the Commission to Eliminate Child Abuse and Neglect Fatalities logo.

REPORT TALKING POINTS AND

FREQUENTLY ASKED QUESTIONS

**Background**

The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) was established by Public Law 112-275 (112th Congress), the Protect Our Kids Act of 2012, to develop a national strategy and recommendations for reducing fatalities across the country resulting from child abuse and neglect.

Composed of 12 members, six appointed by the president and six appointed by Democratic and Republican leaders of the House and Senate, CECANF undertook a two-year process of review, research, and public hearings to study the following key issues:

* The use and effectiveness of federally funded child protective and child welfare services
* Best practices for and barriers to preventing child abuse and neglect fatalities
* How to improve the effectiveness of federal, state, and local data collection systems
* Risk factors for child maltreatment
* How to prioritize prevention services for families with the greatest needs

The Commission heard from government leaders, researchers, public and private organizations that serve children and families, those who work on the front lines of child protection, and more. They found few evidence-based programs to prevent child maltreatment deaths, and there was no state with a sufficiently comprehensive plan to eliminate them.

**Key Findings**

* Oversight for children’s safety and child welfare is spread across a myriad of federal agencies and departments, resulting in a lack of leadership, coordination, and oversight at the federal and congressional level.
* In 2014, the federal government’s National Child Abuse and Neglect Data System (NCANDS) estimated that there were 1,580 child maltreatment deaths in the United States. However, according to many researchers, the actual number of deaths could be at least twice that, since the current system is based on voluntary reporting and inconsistent definitions.
* CPS workers experience high caseloads, frequent turnover, and not enough time to adequately engage families; as many as half of the deaths occurred in families known to CPS.
* Funding and access to high-quality services for parents (such as domestic violence services, substance abuse services, mental health services, home visiting, and more) are often limited or nonexistent, especially in rural areas and particularly on American Indian reservations.
* Legal and policy barriers to information sharing among agencies and between jurisdictions can leave CPS and other child-serving agencies out of the loop regarding information that might save a child’s life.
* CPS workers often lack evidence-based tools to support the best decisions about children’s safety and welfare, and there are few evidence-based programs to support families at risk of a fatality and limited knowledge about the ability of those programs to prevent a fatality.
* Known factors of children who die from abuse and neglect include:
  + Young children are the most common victims (50 percent of deaths occur among infants younger than 1 year old, and 75 percent are under 3).
  + African American children are disproportionately affected (deaths occur at a rate two-and-a-half times greater than white or Hispanic children).
  + The majority of deaths involve neglect (72 percent of all fatalities).
  + Parents, either alone or with others, are the most common perpetrators.
  + A prior report to CPS is the single strongest predictor of a child’s potential risk for injury death before age 5.

The Commission’s recommendations are geared to addressing these findings and challenges to bring about fundamental reform that is informed by better research, data, leadership, and accountability. The report is framed by a need to take immediate action to save lives—action that can then help build the body of knowledge and the infrastructure needed to bring about systemic reform.

## Recommendations for Creating a 21st Century Child Welfare System

The Commission’s recommendations reflect a public health approach to child safety that engages a broad spectrum of community agencies and systems to identify, test, and evaluate strategies to prevent harm to children. This approach has three core components:

**Leadership and Accountability**

Recommendations to enhance leadership at all levels of government include:

* + - 1. Elevate the Children’s Bureau to report directly to the Department of Health and Human Services (HHS).
      2. Require states to develop, consolidate, and implement a coordinated, integrated, and comprehensive state plan to prevent child maltreatment fatalities.
      3. Strengthen accountability measures to protect children from abuse and neglect fatalities.
      4. Hold joint congressional hearings on child safety.

**Decisions Grounded in Better Data and Research**

Recommendations to improve collection, sharing, and analysis of child abuse and neglect data include:

1. Enhance the ability of national and local systems to share real-time data to save children’s lives and support research and practice.
2. Improve collection and interoperability of data about child abuse and neglect fatalities.
3. Conduct child maltreatment fatality reviews and life-threatening injury reviews using the same process and under the same authority within all states. Incentivize states by linking CAPTA funding to completion of reviews.

**Multidisciplinary Support for Families**

Recommendations to promote cross-system prevention and earlier intervention, which are critical to building and sustaining healthier families and communities, include:

1. Ensure access to high-quality prevention and earlier intervention services and supports for children and families at risk.
2. Leverage opportunities across multiple systems to improve the identification of children and families at earliest signs of risk.
3. Strengthen the ability of CPS agencies to protect children most at risk of harm.
4. Strengthen cross-system accountability.

### Recommendations for Saving Children’s Lives Today

The Commission recognized the need for systemic reform, and the fact that large-scale reform does not happen overnight. These recommendations are critical to build infrastructure and the body of knowledge needed save lives immediately:

1. States should review the previous five years of child abuse and neglect fatalities to help them identify family and systemic circumstances that led to child maltreatment deaths. Based on findings, states will develop a fatality prevention plan to prevent similar deaths moving forward.
2. State and local entities should ensure that the most vulnerable children are seen and supported.
3. State and local entities engaged in protecting children, such as law enforcement and CPS, should implement real-time sharing of electronic information on children and families.
4. Child death review teams should review life-threatening injuries, and state fatality prevention plans should use this information as part of a greater focus on prevention.
5. CPS and other providers should employ greater accountability, including implementation of minimum standards and quality training for mandated reporters.

## Recommendations for Populations in Need of Special Attention

Three groups of children present unique challenges when it comes to preventing child abuse and neglect fatalities: children known to the CPS system today who are at high risk of an abuse or neglect fatality, American Indian/Alaska Native children, and African American children. Recommendations to support these children and their families include:

1. Analyze data from past fatalities to identify the children who are at greatest risk right now.
2. Improve and support data collection about child abuse and neglect fatalities of AI/AN children, and integrate the data into national databases for analysis, research, and the development of effective prevention strategies.
3. Improve collaborative jurisdictional responsibility for AI/AN children’s safety.
4. Designate one person or office to represent federal leadership in the prevention of AI/AN child maltreatment fatalities and to coordinate efforts with tribes and ensure parity with states with regard to resources.
5. Conduct pilot studies of place-based intact family courts in communities with disproportionate numbers of African American child maltreatment fatalities to provide preemptive supports to prevent such fatalities.
6. Ensure that quality services are available to all children and families and that all families are treated equitably.

**Funding and Resources**

The Commission recommended that Congress establish a multiyear innovation program to finance the development and evaluation of promising multidisciplinary prevention initiatives to reduce child abuse and neglect fatalities.This innovation fund would provide participating states with resources to design, implement, and evaluate these prevention initiatives at the state or regional level, as outlined by states in their state fatality prevention plans. This model is based on the demonstrated success of the Centers for Medicare and Medicaid Innovation established by section 3021 of the Patient Protection and Affordable Care

Act.

The Commission also recommended that existing entitlement programs utilize flexible funding to provide critical intervention services in mental health, substance abuse, and early infant home visiting services.

**Conclusion**

CECANF’s recommendations take a public health approach, linking CPS agencies with partners in the community to build support for and resilience within families before crises occur. Through implementation of these recommendations, we will be creating a learning laboratory, building from pilot sites, testing ideas, and learning from one another.

The approach outlined in the Commission’s report will support stronger CPS agencies that are better able to use data to identify and protect children who have been harmed and those who are at risk of a fatality. CPS leaders and staff will be held accountable for doing the job they are trained and committed to do. At the same time, the many other agencies and systems that touch the lives of children and families will share data and information to ensure that families and communities get the support they need to build on family strengths and keep children safe. This 21st century child welfare system will engage partners in the AI/AN communities to tackle the unique complexities of tribal sovereignty that impact child fatalities and will address disproportionality head on to eliminate fatalities equally among all communities.

Applying what we know today and using that knowledge to save lives and bring about fundamental reform will help us achieve the goal of a 21st century child welfare system in which children thrive and no child dies from abuse or neglect.

For a copy of the full report, go to: <https://cybercemetery.unt.edu/archive/cecanf/20160323195035/http://eliminatechildabusefatalities.sites.usa.gov/>.

**Q&A**

*Q: How can predictive analytics be accurate when the sample size of child deaths is so small?*

A: Advances in technology and data mining over the past decade have allowed us to make incredible strides in predicting which children are most at risk for abuse and neglect. We can’t identify exactly who the next victim will be, but we know a remarkable amount about the characteristics of the children who die and their families. We also know that our current network of services and supports does not adequately ensure safety for these children by strengthening and supporting their caregivers. Predictive analytics are meant to help determine how we can best direct resources to the children who are most at risk.

*Q: Would these recommendations result in a situation where a child is removed from the home simply based on risk factors present in the family, before any evidence of abuse?*

A: The goal is to proactively deliver resources to prevent child abuse and understand more about the fatalities that can occur as a result -- not to remove children from their homes based on risk factors alone. The Commission’s recommendations are meant to improve prevention, deliver the supports that can help families in crisis, and encourage earlier intervention programs that are critical to sustaining healthy families.

*Q: The Commission’s report recommends focusing on African American children, who are 2.5 times as likely to die of abuse and neglect compared to Hispanic or White children. Could the use of predictive analytics result in the unfair targeting of African American families and children?*

A: The goal is to create a system where all children are equally protected and their families equally supported, regardless of race, ethnicity, income, or where they live. The Commission recommends the establishment of pilot studies in communities where data shows that African American families are disproportionately affected by this issue. The goal is to determine preemptive supports to prevent fatalities and deliver family preservation services that are accessible to all families, including African American families.

*Q: Do you think that implementing these recommendations could increase the number of children being placed in foster care?*

A: Placement in foster care doesn't equate to safety for children. Strong families are necessary to keep children safe. The Commission’s recommendations are intended to ensure children are in safe permanent families in supportive communities. One of the goals of this report is to reduce the number of children in foster care. Removal and placement, even with relatives, should not be the “default” option when it comes to child safety. By targeting the children at the highest risk of abuse, we can intervene earlier and direct support services so we can keep children at home with their parents whenever possible.

*Q: The Commission recommended that states conduct an analysis of child abuse and neglect fatalities over the previous five years to identify children at risk. Are any states undertaking this review?*

A: Yes, there are currently six states that have started this review process: Alaska, Connecticut, Illinois, Indiana, Maine and Oklahoma.

*Q: Is it really possible to get to “zero” child abuse and neglect deaths? Won’t there always be some cases that cannot be prevented by CPS?*

A: When Congress authorized the Commission, they recognized that child abuse and neglect fatalities are a complex, intractable problem. While we will not end child abuse and neglect deaths overnight, the recommendations outlined in the report can *immediately* begin to protect children and reduce deaths from abuse and neglect. We still have a lot to learn in order to end child abuse and neglect deaths entirely, but believe that goal is possible through better leadership, access to data, a multi-disciplinary approach and more effective, evidenced-based interventions.

*Q: What were the White House and Congress reactions?*

A: The Commission met with the Obama Administration, House Ways and Means and Senate Finance Committee to present the findings and recommendations.  The Obama Administration’s Department of Health and Human Services, in a report to Congress, signaled their intention to advance 60% of the recommendations of the Commission.  Also, the Obama Administration’s Department of Justice announced a $6 million grant program to build on past efforts and existing partnerships to establish a more robust and data-driven approach to address and eliminate serious child injuries, near fatalities, and deaths due to victimization. We look forward to working with the Trump Administration and on Capitol Hill in the coming months to support policy change tied to these recommendations.

*Q: How do we bring about change in accountability for multi-system impact?*

A: It needs to happen at all levels of government – from the federal to the local level. It will require greater coordination and communication between agencies.

*Q: Can there be a dialogue with CMS about reimbursement strategies?*

A: The Within Our Reach office continues to coordinate efforts with CMS and other agencies to support both flexible funding and reimbursement. We are also looking at ways to support the establishment of an Innovation Center similar to the one CMS currently oversees on ACA funding.

*Q: What would the Within Our Reach initiative ask us to do to build public and political will?*

A: We would ask stakeholders from across the spectrum to engage your community in raising public awareness and in outreach to key leaders to support the recommendations and call for both policy and practice changes. This toolkit is designed to assist in those efforts.

*Q: What are the thoughts from the Commissioners about poverty, overcrowded housing, domestic violence, violence in general? How did they rise up in the discussions, report and recommendations?*

A: All of these contribute to the issue. Stronger, more resilient families and communities are at the heart of the issue. By providing more up-stream services, our goal is to help families before they reach the critical stage.

*Q: How did the Commission think about the parents who show up in the CPS system who were in the system as children? How do we help heal their trauma?*

A: Children who grow up in the CPS system are more likely to have their children do the same. A population health approach that provides more preventative, up-stream services is designed to break that cycle.

*Q: As there is a request to increase the number of investigations of referrals, is there an understanding that this will require more workers?*

A: Workload capacity and training were issues identified by the Commission. We have called for a multi-disciplinary approach that shares accountability among more agencies than just CPS.

POWERPOINT PRESENTATION

[Double click on slide to launch PowerPoint presentation]:



FEDERAL LEGISLATION IMPACTING CHILD WELFARE

Available online at <https://www.childwelfare.gov/pubs/otherpubs/majorfedlegis/>. Fact sheet is courtesy of the Child Welfare Information Gateway.



SAMPLE STATEMENT IN SUPPORT OF RECOMMENDATIONS



AAP Statement on Commission to Eliminate Child Abuse and Neglect Fatalities Report 3/17/2016 by: Benard P. Dreyer, MD, FAAP, president, American Academy of Pediatrics

The American Academy of Pediatrics (AAP) welcomes a new report out today from the Commission to Eliminate Child Abuse and Neglect Fatalities (the Commission) addressing one of the most tragic, preventable outcomes of child maltreatment: child deaths. The Academy has been working closely with the Commission throughout its development of the report and championed the Protect Our Kids Act of 2012, which authorized its formation.

The AAP supports the report’s overall roadmap of recommendations for Congress and the Administration to prevent child fatalities and protect especially vulnerable children from harm. “Too many children are dying from abuse and neglect. The U.S. Department of Health and Human Services’ Administration for Children and Families estimates that more than 1,500 children died as a result of maltreatment in fiscal year 2014. Nearly three­ quarters of those deaths occurred among children younger than three years old. This is an unacceptable statistic that represents a complete breakdown of children’s most basic needs. We can and must do better. “Given the endemic nature of child maltreatment in the United States, the AAP applauds the Commission for recognizing that solutions to child maltreatment fatalities should not only target the prevention of future deaths, but also must encompass prevention of child maltreatment itself in the first place. Adverse childhood experiences, including abuse and neglect, witnessing domestic violence, parental substance abuse, parental mental health problems, and poverty are risk factors for maltreatment and contribute to lifelong negative health implications for children experiencing them.

The AAP recently issued its first ever policy statement on poverty that encourages advocating for strong federal anti­poverty and safety net programs, and the Commission rightly recognizes the same need as an integral element of child abuse and neglect prevention.

“The Commission’s report maps out a series of recommendations that will inform future efforts on Capitol Hill to protect children from maltreatment and death. As Congress turns attention to reauthorizing the Child Abuse Prevention and Treatment Act next year, and to funding efforts like improved training for mandatory reporters and supporting child death review teams, this report will serve as a critical resource to guide their efforts. The AAP thanks the Commission, and looks forward to ensuring that children’s needs are addressed and prioritized.” ### The American Academy of Pediatrics is an organization of 64,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well­being of infants, children, adolescents and young adults. For more information, visit www.aap.org and follow us on Twitter @AmerAcadPeds.

SAMPLE POLICY STATEMENT

# PCAA policy statement on Commission to Eliminate Child Abuse and Neglect Fatalities final report

On March 17, the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) released its final report, "*Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities."*Congress passed the Protect Our Kids Act of 2012, establishing the Commission to develop a national strategy and recommendations for reducing fatalities resulting from child abuse and neglect [P.L. 112-275]. The report detailing their findings and recommendations was transmitted to Congress and the President after two years of deliberations.

The comprehensive reports calls for new and stronger laws, greater coordinated action and collective responsibility, measurement across agencies, states and within communities, and further investment, oversight, and enforcement across all levels of government. Some of the recommendations put forth by Prevent Child Abuse America are included in the final report and the recognition the report gives to our contributions is greatly appreciated.

One of the reoccurring themes of the report was the emphasis on early childhood home visiting as a key approach to reducing maltreatment fatalities. We agree with this and many of the Commission’s recommendations; however, we feel we owe it to the children, and our future, to outline a specific course of action with an emphasis on a sense of urgency. After a long national history of following old patterns, there needs to be a shift in how the country prioritizes our children in policies and budgets. An increase in preventive services funding with a focus on prioritization of primary prevention strategies and a collective recognition that the healthy development of children is the shared responsibility of other societal institutions such as corporations, faith based communities and local service organizations must replace the current concentrated focus on "late-end, crisis-oriented, intrusive, and expensive interventions."

We wish the Commission had called for a new direction in how we currently invest in healthy child development and well-being. The Commission highlights "these approaches are promising, but the Commission found no state or local response that included all the elements we believe are necessary to achieve widespread, lasting results when it comes to preventing child fatalities." However, the nation has no collective framework to achieve this goal and states are already struggling to comply with dozens of requirements, often with little guidance and flat line funding.

Specific recommendations regarding data-sharing, cross-notification for allegations, research and new reviews, focus only on standardization and elimination of fatalities but can also help to identify and improve prevention strategies. Research confirms strategies that start at birth and even earlier to prevent or counter adverse childhood experiences and promote safe, stable, nurturing relationships and environments can make a bigger impact than responding after trauma occurs.

We believe in the Commission’s work and recognize that there are a wide variety of recommendations that can and hopefully will move the field forward toward a better future for our nation’s children. We agree with the Commission that a public health approach that promotes the healthy development and wellbeing of children, tackles complex social problems and supports community change is the right course of action. Prevention of child abuse and neglect should be a national priority and we hope Congress and the Administration acts urgently to prioritize the following recommendations in the report:

* Increase access to evidence-based home visiting programs and allow states more flexibility toward investing in evidence-based strategies. Including supporting flexible funding in existing entitlement programs to provide critical services in mental health, substance abuse, and early infant home visiting services to support identification and mitigation of risk within families.
* Establish a multiyear innovation program to finance the development and evaluation of promising multidisciplinary prevention initiatives to reduce child abuse and neglect fatalities. The innovation fund would provide states with resources to design, implement, and evaluate prevention initiatives at the state or regional level.
* Increase multidisciplinary support for families by proactively reducing familial and community stressors, through a continuum from prevention to intervention and across multiple systems to improve identification of children and families at the earliest signs of risk. Including cross sector engagement at the parent, family, neighborhood, and system levels. All the systems that interact with families must serve as touch points for proactive prevention and targeted support.
* All have a role to play to ensure that help is available when families need it through services and supports such as prenatal care, mental health services, evidence-based home visiting programs, employment, education, parent partnerships, housing support, early childhood education, and parent skills training, as well as substance abuse, mental health, and domestic violence programs.
* There is little federal oversight and enforcement of the Child Abuse Prevention and Treatment Act (CAPTA) implementation. The federal government does not provide needed guidance on implementing its requirements, nor does it adequately monitor or enforce the required provisions. This lack of attention to the issue in policy guidance hinders the ability of state officials and communities to develop or implement prevention practices.
* Hold joint congressional hearings on child safety in committees that oversee CAPTA, title IV-E, title IV-B, and Medicaid to better align national policies, resources, and goals pertaining to the prevention of and response to safety issues for abused or neglected children.
* Screening for maternal depression during pediatric visits is a strategy to link parents with mental health treatment. Research found targeted screening and intervention for parents experiencing toxic stress and depression can greatly improve parental caregiving capacity. Enable reimbursement for mental health and substance abuse services for a parent under a child’s EPSDT if those services are deemed necessary for the safety and healthy development of the child.
* Prioritize the interventions to reduce maltreatment that have shown promise, particularly shaken baby syndrome. These interventions target parent skill-building at the time of pregnancy or early childhood, either in the hospital or at home. The Office of Adolescent Health should work with grantees to ensure that education on crying babies and safe sleep become a routine part of education efforts with parents.
* Increase federal leadership through research and policy to guide states on how to shape their mandatory reporter laws and efficacy of training programs. Research studies indicate that professionals who are mandatory reporters have varying levels of knowledge about child abuse and neglect reporting. Federal legislation should include a "minimum standard" designating which professionals should be mandatory reporters, and training should be an allowable expense under title IV-E administration.
* Ensure that HRSA and CDC expand the rollout of evidence-based screening tools for Adverse Childhood Experiences (ACEs) and parental risk. The tools should be nonproprietary to ensure expanded access. Screenings must be supported with access to effective, high-quality treatment services to address the identified needs of both parent and child.
* Capitalize on state and payer investment in primary care medical homes and health homes to increase access to trauma-informed programs (for both parents and children), home visiting services, and other family-based social services within primary care settings.
* Elevate the Children’s Bureau to report directly to the Secretary of HHS. Increase the authority of the Children’s Bureau to meaningfully coordinate efforts across federal programs. The Children’s Bureau has primary responsibility for overseeing federal programs aimed at preventing child abuse and neglect and has not provided states or localities with clear direction on how to develop effective strategies for keeping children safe from abuse and neglect.
* Develop standard definitions, investigative procedures, and reporting requirements across all 50 states. Inconsistent state definitions of maltreatment, differing state legal standards for substantiating maltreatment, and barriers to multidisciplinary coordination compromise the ability to obtain comprehensive information. Nationally there are important steps we need to take to achieve more accurate counting and better understand what works.
* Provide adequate funding for access to high-quality services for parents (such as domestic violence services, substance abuse services, mental health services, home visiting, and more) that are often limited or nonexistent, especially in rural areas and particularly on American Indian reservations**.**Effecting change in families requires targeted and responsive services and supports that address the underlying issues that led to a report in the first place.

Conclusion:

We applaud the Commission’s work and final report and appreciate the attention the Commission’s work brought to this issue. We urge Congress and the President to act today with a sense of urgency on these recommendations. The report highlighted a lot of what we already know: there is no silver bullet and it takes a comprehensive strategy with a continuum of programs and services to support families and reduce risk.

We hope Congress leads the development of a coordinated national response that reflects and responds to the urgency of the issue. We hope they focus beyond only preventing fatalities to overall abuse and neglect because fatalities cannot be prevented if child abuse and neglect is not prevented. A thoughtfully developed comprehensive continuum of frontend primary prevention services and systems at all levels of the social ecology would be more impactful than a scattering of programs. What is needed is a comprehensive road map or strategy that promotes the wellbeing of all children energized by a shared vision that ***every***child deserves the right to have a great childhood free from abuse and neglect.

The Commission recognized home visiting as an important intervention to reduce fatalities. Prevent Child Abuse America will continue to contribute our efforts through our evidence-based home visiting program, Healthy Families America, to strengthen families and prevent child abuse and neglect. The report should become the starting point for a call for universal services, a substantial increase in funding and action plans developed by each state based upon a national vision that every child deserves that great childhood.

REFERENCE LIST OF CECANF RECOMMENDATIONS[[1]](#footnote-1)

**RECOMMENDATION 2.1:**

The administration and Congress should support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities.

The steps in this process are as follows:

2.1a HHS should provide national standards, proposed methodology, and technical assistance to help states analyze their data from the previous five years, review past child abuse and neglect fatalities, and identify the child, family, and systemic characteristics associated with child maltreatment deaths. HHS also should encourage states to explore innovative ways to address the unique factors that states identify as being associated with higher rates of child abuse and neglect fatalities.

2.1b States will submit a methodology to HHS for approval, describing the steps they would like to take in using data to identify under what circumstances children died from abuse or neglect during the previous five years.

2.1c After HHS approval, states will identify and analyze all of their child abuse and neglect fatalities from the previous five years to identify under what circumstances children died from abuse or neglect, protective factors that may prevent fatalities from occurring, and agency policies and practices across multiple systems that need improvement to prevent fatalities.

2.1d Based on these data, states will develop a fatality prevention plan for submission to the HHS Secretary or designee for approval. State plans will be submitted within 60 days of completing the review of five years of data and will include the following:

1. A summary of the methodology used for the review of five years of data, including specifics on how the reviewers on the multidisciplinary panels were selected and trained.
2. Lessons learned from the analysis of fatalities occurring in the past five years.
3. Based on the analysis, a proposed strategy for (1) identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data) and (2) putting immediate and greater attention on these children.
4. Other proposed improvements as identified through child fatality review teams.
5. A description of changes necessary to agencies’ policies and procedures and state law.
6. A timeframe for completing corrective actions.
7. Identification of needed and potential funding streams to support proposed improvements as indicated by the data, including requests for flexibility in funding and/or descriptions of how cost savings will be reinvested.
8. Specifics on how the state will use the information gained from the review as part of its CQI process.

2.1e If states find during the review of five years of data that investigation policy is insufficient in protecting children, their plans should ensure that the most vulnerable children are seen and supported. States should review current screen-out policies to ensure that all referrals of children under age 3 and repeat referrals receive responses. In addition, investigation policy should be reviewed to ensure that reports for children under age 1 are responded to within 24 hours. Alternatives to a CPS agency investigation should be considered. Congress and states should fund the necessary resources. Children under age 5 and children with prior CPS reports should be prioritized for home visiting programs.

2.1f Once their fatality prevention plan is approved, states will implement this plan by identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data), putting immediate and greater attention on these children, and conducting multidisciplinary visits and reviews of cases to determine whether the children are safe and whether families need different or additional supports, services, or interventions. If children living at home with their families are found to be unsafe, services should be provided in order to ensure they can be safe in their home. If removal is determined to be necessary, all existing state and federal due process laws remain in effect. Home visits should only be conducted under state-authorized policies and practices for CPS investigations.

2.1g Once a state begins the review of current open cases, as outlined in its fatality prevention plan, each state should provide a report to HHS every month until conclusion of the review.

2.1h HHS will increase system capacity at the national level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities. HHS will establish a Federally Funded Research and Development Center (FFRDC) on Preventing Child Abuse and Neglect Fatalities to collect data from the states and share it with all those who submit data so that state and local agencies can use this data to inform policy and practice decisions (see Recommendation 6.1c) 49 within our reach: a national strategy to eliminate child abuse and neglect fatalities saving children’s lives today and into the future.

2.1i: We strongly recommend a significant appropriation of funds by the federal government to strengthen the child protection system by implementing Recommendation 2.1. There were four different views offered on the funding needed to achieve this goal of fundamentally reforming the country’s child welfare system.

1. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded and recommends that Congress immediately authorize and then appropriate at least a $1 billion increase to the base allotment for Child Abuse Prevention and Treatment Act (CAPTA) as a down payment on the funding necessary to ensure that state CPS agencies are consistently effective and have sufficient funding to keep children protected and that families receive the services and supports they need to ensure their children’s safety. These Commissioners further believe that the first year of funding should support state efforts to implement the case reviews of children known to CPS. This will help to ensure children’s continued safety and determine the broader reforms necessary both to better protect children from abuse and neglect generally and to dramatically reduce child abuse and neglect fatalities. Thereafter, the ability of a state to draw down its share of these new funds will be contingent upon the state having a fatality prevention plan in place and approved by HHS to fundamentally reform the way the child welfare system is designed and delivered with the goal of better protecting children and significantly reducing child abuse and neglect fatalities and life-threatening injuries.
2. One group of Commissioners recommends an increase in funding but leaves the responsibility to Congress to identify the exact amount of funding needed by all responsible agencies to carry out activities in this goal, sources of that funding, and any offsets in funding that are available to support this recommendation.
3. One group of Commissioners recommends that initial costs be covered by existing funding streams, cost-neutral waivers for children ages 0-5, and a prioritization of services for children ages 0-5 who have been demonstrated to be at the highest risk for a later fatality. An overhaul to the structure of federal funding is required to better align resources pertaining to the prevention of and response to safety issues for abused or neglected children. Furthermore, we still have few approaches, programs, or services that demonstrate evidence in reducing child abuse and neglect fatalities. Rather than continuing to fund programs with no evidence of effectiveness, we should support state and local funding flexibility, innovation, and research to better determine what works. The child welfare system is woefully underfunded for what it is asked to do, but a significant investment needs to wait until additional evidence is developed to tell us what works.
4. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded but does not favor making a request for specific dollar amounts in this report. However, if funding is recommended, it should be recommended for all recommendations made by this Commission. Many of the recommendations proposed will require dollars, and all of the recommendations will work toward reducing child abuse and neglect fatalities.

**RECOMMENDATION 3.1:**

Address the lack of data on AI/AN children who die from child abuse and neglect by working with tribes to improve and support data collection and by integrating the data into national databases for analysis, research, and the development of effective prevention strategies.

**Executive Branch and Congress**

3.1a Mandate that the Bureau of Indian Affairs (BIA) immediately implement the practice of distinguishing child and adult homicide victims when reporting fatalities in Indian Country.

3.1b Mandate that the FBI identify key data that tribes could track and that the BIA could collect. At a minimum, the FBI should ask BIA to use the National Incident-Based Reporting System (NIBRS) or request that BIA provide more detailed child-specific information. BIA and FBI data collection about AI/AN children and child fatalities should be coordinated to be complementary and comprehensive.

3.1c To generate accurate crime reports for Indian Country, amend FBI reporting requirements for state and local law enforcement agencies’ crime data as follows: (1) include information about the location at which a crime occurred and victims’ and offenders’ Indian status; and (2) require reservation-level victimization data in its annual reports to Congress on Indian Country crime.

3.1d Mandate that tribal data on AI/AN child abuse and neglect and AI/AN child abuse and neglect fatalities be reported in NCANDS.

3.1e Create a pilot program to support the coordinated collection of child welfare and criminal justice data related to child abuse and neglect fatalities in select tribal communities and states.

3.1f Ensure the accuracy of data/information and ensure that tribes have the capacity and tools to provide that data/information.

**States and Counties**

3.1g The National Association of State Registrars should work with states to coordinate the addition of tribal affiliations on death certificates.

**RECOMMENDATION 3.2:**

Improve collaborative jurisdictional responsibility for Indian children’s safety.

There must be collective responsibility for children’s safety in order to curtail the death of children in Indian Country. No one jurisdiction, be it the federal government, a state, or a tribe, is able to adequately overcome the jurisdictional hurdles that continue to bar proper prevention and intervention strategies.

**Executive Branch**

3.2a Taking into account already existing tribal structures, require that there be a jurisdictional committee composed of both state and tribal leaders to determine jurisdictional issues in criminal matters associated with child abuse and neglect fatalities and life-threatening injuries.

3.2b The federal government should release an RFP (request for proposal) for demonstration projects using a multidisciplinary approach to address the needs of AI/AN children and their families that requires tribal, federal, and state partnerships.

**RECOMMENDATION 3.3:**

Designate one person or office to represent federal leadership in the prevention of AI/AN child maltreatment fatalities and to coordinate efforts with tribes and ensure parity with states with regard to resources.

**Executive Branch and Congress**

3.3a Mandate the appointment or strengthen an existing role of a staff person within the administration with oversight over every federal department concerning child abuse and neglect fatalities of AI/AN children. This person should be looking at tribal policy in each department and reporting to someone in the White House with the authority to convene federal departments and hold them accountable.

3.3b Explore alternatives to current grant-based and competitive Indian Country criminal justice and child welfare funding in the Department of Justice to ensure that all tribes have fair opportunity for access to those funds.

3.3c Bring funding for tribal systems providing services and support in the area of child maltreatment into parity.

3.3d Work to provide for the delivery of mental health services through Medicaid and title IV-B. In addition, tribes should be able to access case management, case monitoring, and supports necessary to maintain children within the home, beyond the standard work day hours of 9:00 a.m. to 5:00 p.m.

3.3e Ensure that tribes are provided with adequate funding for child abuse and neglect reporting.

3.3f Create consistent tribal title IV-E guidance and improve the timeliness of the title IV-E assistance and reviews for tribes. In consultation with tribes, Congress and the administration should consider flexibilities in the title IV-E program that will help the tribes implement direct tribal IV-E in the context of sovereignty.

Note: Additional recommendations made by stakeholders specific to AI/AN populations are available in Appendix G.

**RECOMMENDATION 4.1:** Conduct pilot studies of place-based Intact Family Courts in communities with disproportionate numbers of African American child fatalities to provide preemptive supports to prevent child abuse and neglect fatalities. Use public/private partnerships to develop place-based pilots focused on communities with disproportionate child abuse and neglect fatalities among families of color to address the needs of young children (5 years old and younger) where there is a substantial risk of abuse or neglect. Elements of the Intact Family Court would include the following:

* Referrals to the court would come from medical workers, law enforcement, clergy, caseworkers, or other mandated reporters.
* There would be a voluntary process for families.
* Initial intake would include a physical examination for every child.
* A judge would appoint a guardian ad litem, instead of a lawyer, for the child. (No lawyers would be engaged.)
* Assessment would be made to provide focused coaching and supportive services to the family.
* This would be a confidential process.
* The caseworker would drive the Intact Family Court process and still pursue a more formal dependency process if necessary.
* The court’s role would be broadened to be a resource both in the Intact Family Court, as well as in the current role in more formal dependency proceedings. The Intact Family Court would provide preemptive sup-ports to prevent child abuse and neglect fatalities. The process could have similarities among the pilots without being too prescriptive to address the unique needs in a specific community and provide targeted supports to families.

**Congress**

4.1a Congress should incentivize the establishment of Intact Family Court demonstration projects that feature a multidisciplinary team approach in order to promote healthy families and communities where there is a disproportionate incidence of child abuse and neglect and child abuse and neglect fatalities. This approach should not be limited to support through federal funds but could be implemented through public/private partnerships.

**RECOMMENDATION 4.2:**

Ensure that quality services are available to all children and families and that all families are treated equitably.

Quality services (i.e., services that are effective, culturally appropriate, and targeted) are needed to support children and their families who are disproportionately represented in child welfare and other child-serving systems. Services other than foster care must be identified and implemented. Particularly in communities disproportionately represented in child welfare and with a higher incidence of child abuse and neglect fatalities, efforts at the federal, state, and local levels need to address quality with the same emphasis as availability and accessibility.

**Executive Branch**

4.2a Ensure that the newly elevated Children’s Bureau addresses racial equity and disproportionality in child welfare through guidance and policies on agency self-assessment, worker training, and use of decision-making tools.

4.2b Incorporate into the Child and Family Services Reviews (CFSRs) an indicator of the degree to which racial disproportionality is found within various aspects of a state’s child welfare system.

4.2c Provide guidance, through the regulatory process, on best practices in the use of Structured Decision-Making (SDM) tools in areas where a disproportionate number of child abuse and neglect fatalities have been documented, to effect reduction of bias in child welfare systems’ screening, investigations, and interventions. 9

4.2d Encourage states to promote examples, such as the National Council of Juvenile and Family Court Judges (NCJFCJ) Bench Card, to expose practitioners to decision-making tools that are focused on addressing bias directly.

4.2e Where disproportionality is pervasive, prioritize training of the child welfare workforce, partners, and mandated reporters on the topics of (1) family engagement, development, and strengthening; (2) understanding distinct racial and ethnic cultures and racial and ethnic cultural norms and differences; (3) understanding the historical context of racism; (4) understanding and recognizing biases; and (5) how biases can impact assessment of risk, access to services, and delivery of services.

4.2f Require racial equity training across federal, state, and local child welfare agencies and other child-serving systems to ensure that families disproportionately represented are served and supported by a workforce that is trained, prepared, and mobilized around equitable decision-making and shared accountability.

4.2g Require racial equity impact assessments to address issues of disproportionality and disparities at the federal, state, and local levels, when utilizing predictive analytics to develop prevention and intervention strategies. A racial equity impact assessment is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision.56

**Congress**

4.2h Promote examples such as the focused efforts in Sacramento County, CA, and Michigan in order to inform states and other communities in the replication of a balanced, data-informed, community-driven response to address the reduction of child abuse and neglect fatalities.

4.2i Incentivize states to implement funding mechanisms that integrate assessments, metrics, and accountability structures to ensure that the quality of services is a fundamental component of any program/service approach that is serving disproportionately represented children and their families, with ongoing continuous quality improvement (CQI) strategies also integrated.

4.2j Promote examples from communities and/or also fund demonstration projects that leverage community partnerships (i.e., neighborhood-based work, faith-based partners, and others) to provide supports and services to families to improve outcomes and reduce child abuse and neglect and child abuse and neglect fatalities for children and families who are disproportionately represented.

4.2k Promote focused research on how implicit biases impact assessment, access to services, and service delivery. “Abusive” head trauma might be an area for a specific study on how white children and nonwhite children are assessed and related services are identified and provided.

Note: Additional recommendations made by stakeholders specific to disproportionality are available in Appendix G. 10

**RECOMMENDATION 5.1:**

Create an effective federal leadership structure to reduce child abuse and neglect fatalities.

**Executive Branch**

5.1a Elevate the Children’s Bureau to report directly to the Secretary of HHS. Require the HHS Secretary, in consultation with the Children’s Bureau, to report annually to Congress on the progress of the implementation of the recommendations of this Commission. A primary responsibility of the newly elevated Children’s Bureau will be to ensure that federal child abuse and neglect prevention and intervention efforts are coordinated, aligned, and championed to reduce child maltreatment fatalities and life-threatening injuries. It would do this by encouraging partnership among all levels of government, the private sector, philanthropic organizations, educational organizations, and community and faith-based organizations. Further, the Children’s Bureau will be responsible for coordinating with other key stakeholders in the relevant offices within HHS and the Departments of Education, Justice, and Defense.

The Children’s Bureau would have the following additional responsibilities:

* Lead the development and oversight of a comprehensive national plan to prevent child abuse and neglect fatalities
* Collect and analyze data from the states’ retrospective reviews of five years of data (see Recommendation 2.1) to contribute to the knowledge base about the causes and circum-stances of child abuse and neglect fatalities
* Review and coordinate approval of state plans, including working with federal partners to facilitate funding flexibility when needed to implement state plans
* Establish national caseload/workload standards
* Fund pilot projects to test the effectiveness of the application of safety science to improve CPS practice. Additional detail about these and other pro-posed responsibilities of the Children’s Bureau are detailed in Appendix H.

5.1b Consider moving the Maternal and Child Health Bureau (MCHB) back into the Children’s Bureau. Many health programs originally created by the Children’s Bureau became the responsibility of MCHB during a reorganization of the federal government in 1969.70 Bringing responsibility for these programs back under the Children’s Bureau would build and reinforce the use of a public health approach to child welfare services.

5.1c Create a position on the Domestic Policy Council that is responsible for coordinating family policy across multiple issues of priority for the administration, one of which would be child abuse and neglect fatalities.

**RECOMMENDATION 5.2:**

Consolidate state plans to eliminate child abuse and neglect fatalities.

**Congress**

5.2a Through legislation, Congress should require states to develop and implement a coordinated, integrated, and comprehensive state plan to prevent child maltreatment fatalities. The state fatality prevention plan should specify how the state is targeting resources to reach children at highest risk for fatalities, as identified by the state’s data mining effort (as described in Chapter 2).Legislation should specify certain safety benchmarks, and all state plans should address common risk factors for child abuse and neglect fatalities, but legislation should allow states local flexibility in designing their plans to best meet the unique needs of their population and build on resources already in place. States should be directed to utilize evidence-based strategies and be responsible for evaluating their effectiveness. The federal government could provide targeted funds to spur innovation and to help states test and evaluate their strategies.

State child fatality prevention plans should take a comprehensive, early intervention approach, with CPS being one of multiple key partners. Core components of state plans should include the following:

Data- The plan’s action strategy must be driven by data (including state needs assessments and cross-system data sharing). Data tracking must include the following:

* Use of three or more data sources in tracking fatalities and life-threatening injuries
* Identification of the ZIP codes and/or census tracks with high rates of child abuse and neglect fatalities and life-threatening injuries
* Partners. The state must have a plan to engage public-private partners, community organizations, faith-based communities, and families. For example, if parental substance use is identified as a significant risk factor for fatality, the plan should reflect coordination and shared accountability between CPS and the state’s substance abuse services.
* Clear interagency roles and responsibilities. The plan should reflect clear and effective programmatic coordination to address risk factors identified through data mining. The plan also may include requests for flexibility in relevant funding streams to better address documented needs.
* Recommendations from fatality reviews and life-threatening injury reviews. Reviews of child maltreatment fatalities and life-threatening injuries will be the basis for recommendations and for establishing cross-system priorities for correcting problems identified and achieving progress toward these priorities.

State public health agencies (including title V programs) should be required through their federal authorizing legislation to assist state child welfare agencies in identifying children most at risk of maltreatment and contribute to the development of the plan for addressing their needs. This plan should be shared with the state court and included in training programs for state court improvement directors using funds already provided under the Court Improvement Program. Congress should direct HHS to provide technical assistance to states in identifying children at greatest risk for child abuse and neglect fatalities and provide training resources.

**States and Counties**

5.2b Prepare state fatality prevention plans on child abuse and neglect fatalities, as required above, under the leadership of the governor’s office. This plan, similar to a comprehensive national plan to prevent child abuse and neglect fatalities, would demonstrate how the state is leveraging multiple federal grant programs whose mission involves child safety and family strengthening toward the goal of preventing fatalities from child maltreatment. At a minimum, the plan should be developed in consultation with the judiciary, agency leaders responsible for child care and early education programs, Medicaid and hospital administration, law enforcement, public health, and child protection.

**RECOMMENDATION 5.3:**

Strengthen accountability measures to protect children from abuse and neglect fatalities.

**Executive Branch**

5.3a Provide examples of best practices in state level policies, including expanding infant safe haven laws to cover infants up to age 1.

5.3b Tribal child protection programs that meet accountability and child safety standards, as outlined in federal guidelines, should be operated and implemented at the discretion of the tribe and should enable the tribe to innovate and develop best practices that are culturally specific, while maintaining those standards.

**Congress**

5.3c Require training and technical assistance for courts on implementation of the federal law relating to the ASFA Reunification Bypass.

5.3d Amend CAPTA to clarify and require that all information currently specified in CAPTA must be released following a death or life-threatening injury from abuse or neglect and must be posted on the state’s website no later than 48 hours after receipt of the report, excepting any information that might otherwise compromise an ongoing criminal investigation. CAPTA should be further amended to require Critical Incident Review Teams (CIRTs) to review all child abuse or neglect deaths and to require that reports issued by the CIRTs be published in full on the state’s website within 12 months of the child’s death. These reviews should be coordinated with the state’s child death and life-threatening injury review programs.

**States and Counties**

5.3e Amend state infant safe haven laws to expand the age of protected infants to age 1 and to expand the types of safe havens accepted, including more community-based entities such as churches, synagogues, and other places of worship. States also should expand public awareness campaigns for safe haven laws, given the correlation between awareness and effectiveness.

5.3f Publish child abuse and neglect fatality information on state public websites at least annually, similar to the approach in Florida.

**RECOMMENDATION 5.4:**

Hold joint congressional hearings on child safety.

**Congress**

5.4a Hold joint congressional hearings on child safety in committees that oversee CAPTA, title IV-E, title IV-B, and Medicaid to better align national policies, resources, and goals pertaining to the prevention of and response to safety issues for abused or neglected children. Coordinating federal child welfare policy in this way would also yield efficiencies through improved governance and oversight.

**RECOMMENDATION 6.1:** Enhance the ability of national and local systems to share data to save children’s lives and support research and practice.

**Executive Branch**

6.1a Spearhead a special initiative to support state and local entities engaged in protecting children, such as law enforcement and CPS, in sharing real-time electronic information on children and families.

Regulations from the U.S. Department of Health and Human Services (HHS) and Department of Justice (DOJ) and state laws should require that state entities share real-time electronic information between agencies engaged in protecting children (specifically, law enforcement, CPS, public health agencies, hospitals and doctors, schools, and early childhood centers). States can find guidance on building such systems by reviewing projects completed under the State Systems Interoperability and Integration Projects (S2I2).

6.1b Increase the interoperability of data related to child protection across federal systems.

Data collected related to child protection and safety sit in a number of different federal, state, and local agencies, including various divisions within HHS such as the Administration on Children, Youth and Families, the National Institute of Child Health and Human Development, the Centers for Disease Control and Prevention (CDC), and the Maternal and Child Health Bureau, as well as other agencies such as DOJ. As a result, our understanding of circumstances that might contribute to child abuse and neglect fatalities is incomplete. Policy and procedures are needed to enable these systems to talk to each other.

6.1c Increase system capacity at the national level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities.

**The Commission recommends establishing a Federally Funded Research and Development Center (FFRDC) on Preventing Child Abuse and Neglect Fatalities** similar to the Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Healthcare. This could be housed within HHS or DOJ. Analyses conducted by this FFRDC must be made available to the Children’s Bureau’s new Coordinating Council on Child Abuse and Neglect Fatalities and shared with all entities that submit data so that state and local agencies can use data to inform policy and practice decisions. (See Appendix H for more details about the Council.)

**Congress**

6.1d Consider what legislative or funding changes would be required to empower the Executive Branch to carry out Recommendations 6.1a: Enhanced real-time electronic data sharing among state agencies engaged in protecting children; 6.1b: Increased interoperability of data related to child protection across federal systems; and 6.1c: Application of the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities.

6.1e Require federal legislation that defines the permissibility of data sharing for children involved in the child welfare system, those who are dependents of active duty military, and those receiving publicly funded prevention services, to require the sharing of information between civilian CPS agencies and Department of Defense family advocacy offices and related agencies.

6.1f Clarify federal legislation that allows CPS agencies access to National Crime Information Center criminal background information.

**States and Counties**

6.1g Require cross-notification for allegations of child abuse and neglect between law enforcement and CPS agencies, implementing a system similar to the Electronic Suspected Child Abuse Report System (E-SCARS) in Los Angeles County.

**RECOMMENDATION 6.2:** Improve collection of data about child abuse and neglect fatalities.

**Executive Branch**

6.2a Rapidly design and validate a national standardized classification system to include uniform definitions for counting child abuse and neglect fatalities and life-threatening injuries. This national maltreatment fatality classification scheme should include criteria, operational definitions, and a process to ascertain fatal and life-threatening physical abuse and neglect. It should reconcile information from multiple agencies, using the U.S. Air Force–Family Advocacy program Central Repository Board Project as a model.

This will require development, field-testing, and implementation of a uniform operationalized definition and decision tree for child abuse and neglect fatalities. The definitions should not rely on agency-specific definitions of child abuse and neglect and should be developed for the purpose of counting and pre-venting fatalities (and include cases that may or may not meet criminal or civil definitions of abuse and neglect for purposes of substantiation or prosecution). The process of determining whether a fatality is due to abuse or neglect using the standardized definition must require the use of multidisciplinary teams (e.g., child welfare, law enforcement, health care) and shared decision-making. States should be required to use these standardized definitions and processes.

6.2b Improve the system of child death investigation and death certification by developing standards of investigation and expertise in investigation and certification.

* Develop a nationally standardized child death investigation protocol for use by medical examiners, coroners, and law enforcement, and update the CDC’s sudden unexplained infant death investigation guidelines.
* Provide national training and resources to encourage widespread use of protocol and guidelines.
* Encourage states to transition from coroner systems to medical examiner systems that utilize forensic pathologists in all suspected child maltreatment deaths.
* Encourage states to establish an administrative position at the state level for an experienced forensic pathologist to provide training and oversight and ensure high-quality, standardized investigations of all sudden and unexpected child deaths.

6.2c Develop the **National Fatal and Life-Threatening Child Maltreatment Surveillance System** as a National Data Repository to collect, analyze, and report data on fatalities and life-threatening injuries from maltreatment. Require states to conduct multidisciplinary reviews of all child maltreatment fatalities and life-threatening injuries, using records from multiple agencies, and to utilize the national standardized classification system (described already in Recommendation 6.2) to classify and count all fatal and life-threatening maltreatment. These data would be reported into the Data Repository. All entities reporting into the Data Repository would have access to the data for the purposes of research and improving practice. The data collected into the repository would include the subset of cases also entered into the NCANDS System, which will remain the CPS reporting system.

6.2d Expand upon the HHS national report of child abuse and neglect fatalities, currently provided in the annual *Child Maltreatment* report, by collecting and synthesizing all available information (cross-agency) on the circumstances surrounding child maltreatment deaths to inform policy. The report should be issued by the **Children’s Bureau’s new Coordinating Council on Child Abuse and Neglect Fatalities**. (See Appendix H for more details about the Council).

See Appendix I for a list of suggested elements that an expanded *Child Maltreatment* report might include. To support states, HHS should prioritize its provision of technical assistance to states to ensure timely and accurate submission of this data.

6.2e Conduct longitudinal research about the leading factors related to child abuse and neglect fatalities of AI/AN children, 18 and under. It may be possible to integrate a longitudinal research component in the Tiwahe Initiative (a partnership between HHS and the Departments of Justice and Interior) currently being piloted in four tribes.

**Congress**

6.2f Consider whether statutory changes and/or additional funding may be required for the Executive Branch to carry out Recommendation 6.2b: Improve the system of child death investigation and death certification by developing standards of investigation and expertise in investigation and certification;

6.2g Amend CAPTA to improve the data on fatalities and life-threatening injuries that states are required to collect and submit to NCANDS until the Data Repository is operational. Consider what additional funding may be necessary to support these changes.

* Building on current policy in CAPTA, all states should be required to collect child abuse and neglect fatality data from all sources (state vital statistics departments, child death review teams, law enforcement agencies, and offices of medical examiners or coroners) and submit consolidated data to NCANDS. To ensure compliance, these data requirements should be placed in authorizing legislation pertinent to programs being asked to share data, including but not limited to title IV-E, title V, the Public Health Services Act, and others.
* Expand the standardized set of data elements required to be submitted into NCANDS for all child abuse and neglect fatalities and life-threatening injuries as defined by the operationalized definitions discussed above. Currently, there are no case-specific (vs. aggregate) data elements in NCANDS that provide any details about the circumstances of a given death. This recommendation would result in a separate fatality/life-threatening injury file within NCANDS with data elements to better understand the circumstances of fatalities to inform practice and policy.
* Require redefining the data element that requires the “number of children reunited with their families or receiving family preservation services that, within five years, result in subsequent substantiated reports of child abuse or neglect, including the death of a child” [CAPTA Sec 106(d)(11)] to include all children in the family reported to CPS, regardless of acceptance or substantiation, who later died from abuse or neglect.
* Add a data element to allow for collection of data about all deaths of children while in foster care or after being adopted from the child welfare system.
* Add data elements as needed to respond to the additional elements required for inclusion in an expanded *Child Maltreatment* report (see earlier recommendation).

**RECOMMENDATION 6.3:** Fatality reviews and life-threatening injury reviews should be conducted using the same process within all states.

**Executive Branch**

6.3a Lead the analysis and synthesis of all child maltreatment fatality and life-threatening injury review information at the national level; include expanded information in the *Child Maltreatment* report, and broadly disseminate findings including to state child welfare programs as well as to title V and CDC programs. This analysis will be conducted within HHS and overseen by the Children’s Bureau’s Coordinating Council for Child Abuse and Neglect Fatalities.

6.3b In order to incentivize states to add the reviews of life-threatening injuries caused by child maltreatment into their current child death review activities, receipt of CAPTA funds should be contingent upon states conducting these reviews. Currently, Wyoming and Oklahoma conduct both types of reviews.

6.3c Develop uniform standards and guidelines for conducting case reviews of maltreatment deaths so that they will lead to improved case ascertainment, agency policy, and practice improvements and actions for prevention.

**Congress**

6.3d Consider whether statutory changes and/or additional funding may be required for the Executive Branch to carry out the preceding recommendations in support of uniform fatality and life-threatening injury reviews.

**RECOMMENDATION 7.1:** Ensure access to high-quality prevention and earlier intervention services and supports for children and families at risk.

**Executive Branch**

7.1a Permit Medicaid reimbursement for evidence-based infant home visiting services provided to youth in foster care who are parents (Medicaid-eligible by definition) to promote expansion of home visiting services to this high risk population.

7.1b Support state waivers that would provide and evaluate the impact of presumptive Medicaid eligibility and reimbursement for parental mental health and substance abuse treatment services on behalf of EPSDT for a Medicaid-enrolled child if those intergenerational services are deemed necessary for the safety of the child.

Enabling reimbursement for immediate mental health services or other necessary treatment services for a parent under a child’s EPSDT benefit would permit providers within states with Medicaid expansion to more quickly access services for parents, and might allow providers within states that have not expanded Medicaid to provide critical services to a family to prevent imminent harm to a child and prevent family disruption. Evaluation of such waivers could provide needed evidence to determine whether the EPSDT benefit to children should be amended through legislation to include parental mental health and substance abuse treatment services if those services are deemed necessary to protect the safety of the child.

7.1c Incorporate maltreatment fatality and serious injury prevention as a core value in the Office of Adolescent Health’s Pregnant and Parenting Teen grant programs. Further, the Office of Adolescent Health should work with its grantees to ensure that education on crying babies and safe sleep become a routine part of education efforts with parents.

**Executive Branch and Congress**

7.1d Mandate the development and implementation of educational curricula connecting youth to their cultural traditions, particularly around native language renewal and positively presented Native American history, to be used at all levels of pre-collegiate education.

7.1e Mandate the development of a culturally accurate assessment of how to provide services optimally within tribes, being informed by tribes, particularly being informed by traditional medicine practitioners within tribes, in the context of federal funding opportunities and practice standards/requirements related to child and family well-being.

7.1f Mandate the implementation of fatherhood initiatives in Indian Country as well as mandating improved drug abuse education programming.

7.1g Promote and facilitate peer-to-peer connections around examples of well-formed efforts focused on AI/AN children and families.

**Congress**

7.1h Maintain flexible funding in existing entitlement programs to provide critical intervention services in mental health, substance abuse, and early infant home visiting services to support earlier identification and mitigation of risk within families at risk for child maltreatment fatalities.

Currently, more than half of the states are operating title IV-E waiver demonstration projects that will end in 2019 and have not been authorized to continue.121 The Commission recommends that Congress reauthorize waiver authority under title IV-E of the Social Security Act.

Reauthorization of waiver authority under title IV-E should not be seen as a substitute for more fundamental title IV-E financing reform, but rather should be utilized to allow states to experiment with new and innovative ideas regarding the administration of the title IV-E program. The Commission supports the Hatch-Wyden legislation, known as the Family First Bill, which would include provisions to include in title IV-E an option for states, as well as tribes who administer a title IV-E program, to operate a statewide prevention program.

7.1i Increase resources for the development, piloting, and scale-up of evidence-based prevention and intervention supports and services. Congress should provide resources for the testing of promising prevention and intervention supports and services.

**States and Counties**

7.1j Test and develop the ability of home visiting to reduce child abuse and neglect fatalities. Utilize the research infrastructure through the national Home Visiting Applied Research Collaborative to support this effort.

7.1k Capitalize on state and payer investment in primary care medical homes and health homes to increase access to trauma-informed programs (for both parents and children), home visiting services, and other family-based social services within primary care settings.

7.1l Ensure that CPS-involved children and families at the greatest risk of fatalities have priority access to effective mission-critical services, especially as they relate to caregiver mental health, substance abuse, insufficient caregiver protective capacities, and domestic and interpersonal violence.

7.1m Prioritize prevention and support services and skill-building for adolescent parents to prevent and address abuse and neglect by young parents, with a particular focus on youth in the child welfare and juvenile justice systems. These young parents have many risk factors, and government systems have access to them and have a heightened responsibility for many of the risk factors that affect their ability to parent effectively.

7.1n Provide direct purchase of services funds to local CPS agencies, ensuring prioritized access to critical services.

**RECOMMENDATION 7.2**: Leverage opportunities across multiple systems to improve the identification of children and families at earliest signs of risk.

**Executive Branch**

7.2a Ensure that other children’s services providers have higher levels of accountability to reduce child fatalities. In health care, Medicaid should create greater accountability for health care providers to screen families at elevated risk for maltreatment and should use payment mechanisms, including reimbursement strategies, to incentivize greater investment in intergenerational services to these families. Communities with home-visiting programs should have greater accountability to demonstrate the connection of these services to highest risk families. Birth hospitals should be held to a higher level of accountability for Plans of Safe Care.

7.2b Ensure that HHS agencies, specifically, CMS, the Administration for Children and Families (ACF), and the Substance Abuse and Mental Health Services Administration (SAMHSA), issue clear and joint guidance to states to aid in effective implementation of Plans of Safe Care. For example, guidance should identify best practices for screening and referrals and should provide model policies and provide information on how states can access federally supported technical assistance. HHS should collect annual data from hospitals and CPS on Plans of Safe Care to learn more about the needs of children at risk of harm and to make appropriate policy updates.

7.2c Ensure that CMS encourages pediatric health information exchanges to share information on prior injury visits across provider systems, so that emergency department and acute care settings can access this information during visits for acute pediatric care and better assess children at risk of abuse and neglect. Clinical decision support in hospitals should enable the identification of abuse and neglect visits.

7.2d Ensure that HRSA and CDC expand the rollout of evidence-based screening tools for Adverse Childhood Experiences (ACEs) and parental risk. The tools should be nonproprietary to ensure expanded access. Screenings must be supported with access to effective, high-quality treatment services to address the identified needs of both parent and child.

**Congress**

7.2e Demand greater accountability from mandatory reporters. Federal legislation should be amended to include a “minimum standard” designating which professionals should be mandatory reporters, and training of these reporters should be an allowable expense under title IV-E administration, so long as the training model is approved by HHS. For mandatory reporters who need to maintain licenses in their fields, training and competency should be a condition for licensure, with responsibility on the licensees and their licensing entity to make sure they refresh competencies over time.

7.2f Amend CAPTA and relevant health policy to clarify the roles and responsibilities at the federal and state level to improve the implementation of CAPTA’s Plan of Safe Care. Clarifications should include a requirement for hospitals’ full cooperation in implementing Plans of Safe Care and specify accountability measures for both CPS and hospitals in the timely development of Plans of Safe Care and referral of services.

**States and Counties**

7.2g Pass state legislation to establish policies for matching birth data to data on termination of parental rights and conducting preventive visits. Can be modeled after Michigan, Maryland, or New York City.

7.2h Expand the screening of caregivers for elevated risk factors, including toxic stress and social determinants of health, and provide early connections to services. Innovation can be strengthened via public-private partnerships that help to eliminate barriers to accessing early infant mental health services that engage parents in strengthening parenting.

7.2i Ensure that health information exchanges facilitate access to injury and health service histories of children at the point of care, especially for children presenting with injuries in hospitals’ emergency departments.

**RECOMMENDATION 7.3:** Strengthen the ability of CPS agencies to protect children most at risk of harm.

**Executive Branch**

7.3a Ensure that HHS and the Department of Justice (DOJ) provide guidance on best practice on screening and investigation models.

**Executive Branch and Congress**

7.3b Mandate the implementation of service approaches that prioritize keeping AI/AN children within their tribes as a primary alternative to out-of-home placement.

**Congress**

7.3c Update federal policy in CAPTA to align with and incentivize best practice in multidisciplinary investigations of child abuse and neglect fatalities. States should have clear policies on when investigations should be conducted by multidisciplinary teams, to include clinical specialists and first responders such as the “Instant Response Team” policy implemented in New York City in 1998 and the co-location of health and law enforcement in El Paso County, Colorado, as part of their “Not One More Child” campaign that began in 2012.

7.3d Require CPS agencies to identify partners/contracted resources for medical review and evaluation; case management for access to voluntary home visiting services; and access for families to domestic violence counseling, mental health services, and substance abuse treatment services.

**RECOMMENDATION 7.4:** Strengthen cross-system accountability

**Executive Branch**

7.4a Require states to articulate in their state plans (as detailed in Chapter 2) how they are approaching coordinated case management for families at high risk of child abuse and neglect fatalities.

7.4b Prioritize the reduction of early childhood fatalities via state or regional demonstration projects within the Centers for Medicare and Medicaid Innovation (CMMI). CMMI or another entity within HHS should provide time-limited funds to test the implementation of promising multidisciplinary prevention initiatives identified within state fatality prevention plans.

7.4c Develop new pediatric quality measures for ensuring follow-up visits for failure to thrive and tracking early childhood injuries.

**Congress**

7.4d Establish a multiyear innovation program to finance the development and evaluation of promising multidisciplinary prevention initiatives to reduce child abuse and neglect fatalities. This innovation fund would provide participating states with resources to design, implement, and evaluate these prevention initiatives at the state or regional level, as outlined by states in their state fatality prevention plans. This model is based on the demonstrated success of the CMMI established by section 3021 of the Patient Protection and Affordable Care Act.

1. Compilation courtesy of Every Child Matters Education Fund [↑](#footnote-ref-1)