Eliminating Child Abuse and Neglect Fatalities in Baltimore City

A Report by the Baltimore City Child Fatality Review Team
Subcommittee on Child Abuse and Neglect

January 2017

Executive Summary

After 2015 saw the highest number of child homicides committed by a parent or caregiver since the inception of Baltimore City Child Fatality Review (CFR), a subcommittee of the CFR Team embarked on a project to uncover the drivers of these homicides in Baltimore City and lay the foundation for a citywide prevention movement.

Contained within this report are the findings of a review of 37 cases of fatal and near-fatal child abuse and neglect and 36 corresponding recommendations for prevention these tragedies. Key revelations included that:

- Victims are predominantly vulnerable infants and toddlers who go unidentified by the system
- Caregivers are struggling with substance use, mental health disorders, intimate partner violence, their own histories of abuse and neglect, and the challenges of poverty, including lack of safe child care
- Early childhood prevention services are not reaching many of the families who may need them most
- Better collaboration can yield rewards for service and investigative agencies aiming to prevent fatalities
- Baltimore City's health care system represents tremendous opportunity for prevention and intervention

Although prevention of child abuse and neglect fatalities may conjure up reforms to the child welfare system, these fatalities are not a child welfare problem but a whole community problem. In fact, most children and families in cases reviewed had never before come to the attention of the child welfare system. Preventing these fatalities requires a public health approach that involves all agencies and providers serving families—and all Baltimore City's residents—and that simultaneously works on multiple fronts to change policy, to improve services, and to mobilize communities.

Tackling, or simply digesting, the 36 prevention recommendations presented in this report may feel daunting, but all are shared here because the urgency of this issue, and the clear need for multipronged approach, warrant sharing them all. This report also makes clear a path forward: focusing in the first year on implementing a core set of high impact recommendations while laying the groundwork for a long-term prevention project through *B'more for Healthy Babies,* Baltimore City's successful strategy for reducing infant mortality and improving the health of the city's young children and families.

With the number of child homicides committed by a parent or caregiver in 2016 surpassing the number from 2015, our city's youngest and most vulnerable residents are depending on us to take action now to save their lives.

HIGH IMPACT RECOMMENDATIONS FOR YEAR 1

Contents

1. Child Abuse and Neglect Fatalities

A 1-year-old boy with developmental delays was found unresponsive in his bed by his mother and was rushed to the emergency department where he died. He was found to be emaciated, and the cause of death was identified as complications of malnutrition. His mother had three older children, was facing eviction, and had numerous service providers coming in and out of the chaotic home for herself and the children, but she lacked family and social support.

A 1-month-old girl died of head injuries, but the autopsy and investigation were inconclusive, leaving the manner of her death "undetermined" whether intentional or accidental. A year later, while under investigation for a serious injury to her subsequent newborn, the girl's mother confessed to a year earlier having brought the infant down hard, hitting her head on a table, in frustration over her inconsolable crying.

A 2-year-old girl was strangled to death by her father after spilling cereal on the bed. She had been removed from the custody of her mother at birth as a result of her mother's challenges with untreated substance use and mental health disorders. Despite living with family members, her father had little support and regularly used harsh discipline. The autopsy and investigation revealed evidence of malnutrition and chronic abuse, which no one in the family had reported.

A 2-year-old boy finally succumbed to the brain injuries he suffered when, at 3 months old, his father attempted to drown him in the bathtub. Twelve years prior, the father had been convicted of second-degree murder for killing his girlfriend's child, but he served only 5 years of his 20-year sentence. No mechanism exists for the child welfare or public health system to have identified his son as at-risk for abuse despite his previous homicide conviction.

Children are not supposed to die, and certainly not at the hands of the people they most trust—their parents and caregivers. Yet they do. In fact, 1,546 fatalities resulting from child abuse and neglect were reported in the United States in 2014—an average of four children dying every day, most of them infants and toddlers.[1] Most researchers and practitioners believe that child fatalities due to abuse and neglect are under-identified and under-reported, estimating that the number of fatalities is at least double the reported number.[2,3,4] No surveillance system exists to collect data and report on near-fatal incidents of abuse and neglect, but research finds that, for every infant under 1 year of age who dies as a result of abuse or neglect, more than 10 infants are hospitalized with life-threatening injuries resulting from abuse.[5,6]

These four heartbreaking stories are among dozens of child abuse and neglect fatality cases reviewed by the Baltimore City Child Fatality Review (CFR) Team. All were ruled homicides—physical assaults or severe neglect by a parent or caregiver that directly resulted in the child's death. Fatal child abuse may involve repeated or chronic abuse over a period of time, or it may involve a single incident, such as suffocating or shaking a baby. Similarly, fatal neglect—which occurs when a child's caregiver fails to care for the child—may also be chronic, as with malnourishment, or involve a single incident, as when a toddler drowns after being left unsupervised in the bathtub.

Child abuse and neglect fatalities are preventable. In most cases, caregivers do not wish to harm their children. Rather, they are often struggling—struggling with substance use and mental health disorders, domestic violence, their own histories of trauma and abuse, and the challenges of poverty, including housing instability and lack of quality, safe child care. Preventing child abuse and neglect fatalities requires a multi-sector, **public health approach**—one that involves the whole community in identifying children and families most at risk, intervening early with services and supports to prevent abuse, and enacting policies that enable families to build resilience and provide safe homes for their children.[7,8,9] We can eliminate these tragedies in Baltimore City by taking action now on behalf of our youngest and most vulnerable residents.

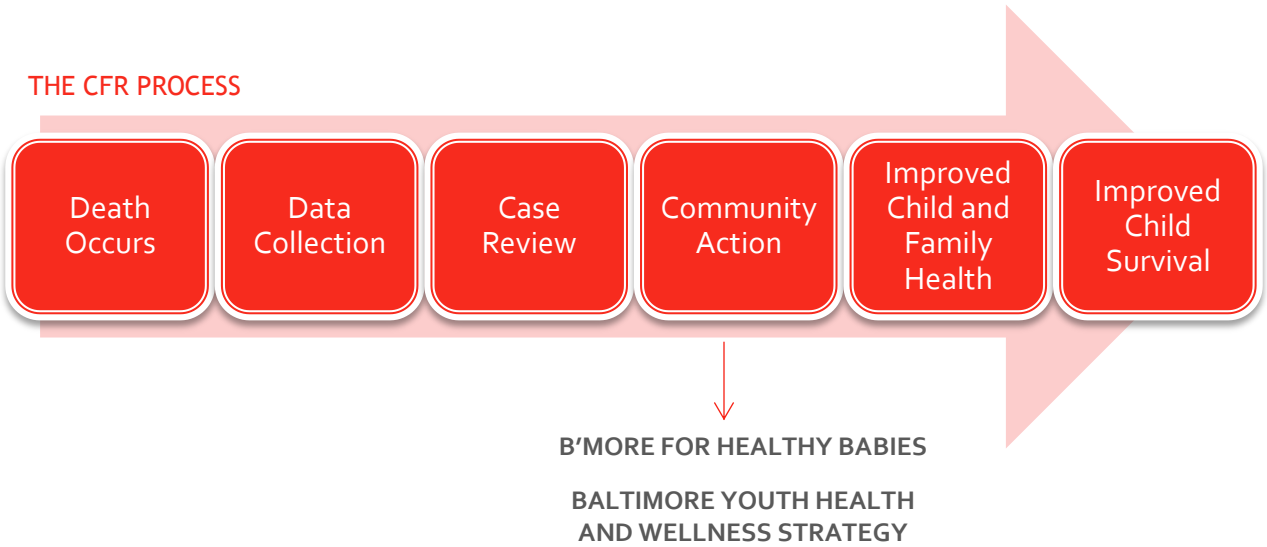
2. Building a Public Health Prevention Strategy for Baltimore City

The Baltimore City CFR Team—made up of representatives of key city agencies and health experts—exists to provide understanding of how and why children in Baltimore die, take action to prevent future deaths, and improve the health and safety of all of Baltimore City's children and families. In January 2016, Baltimore City CFR launched a project to build a citywide strategy to prevent child abuse and neglect fatalities after the year 2015 saw seven homicides committed by parents and caregivers, the most since the inception of CFR.

a. Background: Baltimore City Child Fatality Review

CFR was established in Maryland by Senate Bill 464 of 1999, which created a State CFR Team and Local CFR Teams in every jurisdiction. All 50 states have CFR programs, and more than 1,200 local teams are currently operating in the United States. Coordinated by the Baltimore City Health Department (BCHD), the Baltimore City CFR Team meets every month to review cases of "unusual and unexpected" death in children from birth to age 17 who are residents of Baltimore City. "Unusual and unexpected" deaths are those that result from unintentional injury (e.g., motor vehicle accidents, fires) and intentional injury (e.g., child abuse, gun violence, suicide) and those that are of undetermined manner. Cases are referred to the team by Maryland's Office of the Chief Medical Examiner (OCME). For each case, the CFR Team gathers and reviews information including the autopsy report and health, law enforcement, school, and social services records. Authority for CFR Teams to collect this information is provided by the Code of Maryland Regulations (COMAR) Maryland Health – General Section 5-707. All case reviews are confidential and closed to the public to preserve families' privacy.

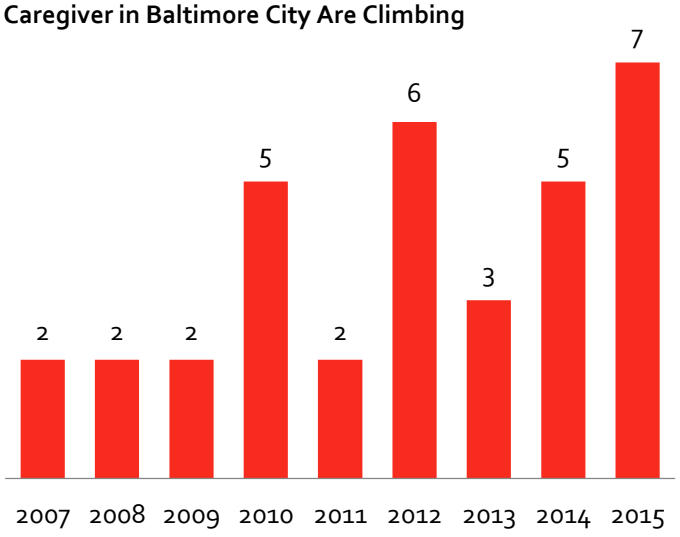
During reviews, the CFR Team strives to identify actions that policymakers, public agencies, community-based organizations, health and social services providers, and families can take to prevent child deaths. Two citywide public health initiatives, *B'more for Healthy Babies (BHB)* and the *Baltimore Youth Health and Wellness (YHW) Strategy,* are closely linked to Baltimore City CFR and serve as its community action arms. BHB, launched in 2009, focuses on reducing infant mortality and is expanding to prevent child abuse and neglect and improve school readiness for children and families through age 5. YHW, launched in 2016 in collaboration with BCHD's Office of Youth Violence Prevention, focuses on improving child health and preventing violence for children and youth ages 6 to 19. Both strategies are led by BCHD's Bureau of Maternal and Child Health and involve more than 100 partners across the public and private sectors.



b. Challenge: Child Abuse and Neglect Fatalities

Child abuse and neglect fatalities in Baltimore City are on the rise. The Baltimore City CFR Team reviewed 34 total homicides committed by parents or caregivers occurring from 2007 to 2015, with a high of seven homicides in 2015. As of this writing, there have been eight confirmed homicides to Baltimore City children committed by a parent or caregiver in 2016, with additional cases still under police investigation and pending a declaration by the OCME of manner and cause of death. In addition to these homicides, the CFR Team routinely reviews fatalities of accidental or undetermined manner in which abuse or neglect contributed to the child's death, as determined through investigation by Child Protective Services (CPS) and/or in the judgment of the CFR Team after reviewing multiple sources of data for the case.

Child Homicides Committed by a Parent or Caregiver in Baltimore City Are Climbing



c. Purpose: Laying the Groundwork for a Coordinated Prevention Effort

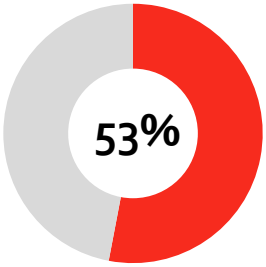
In response to the disturbing increase in homicides committed by parents or caregivers, the Baltimore City CFR Team decided to examine in detail these fatalities, along with additional cases of near-fatal abuse, to identify trends across cases and develop a comprehensive set of recommendations for prevention. These data-driven recommendations are intended to serve as the basis for a coordinated public health prevention strategy for child abuse and neglect to be implemented by BHB and its extensive partner network.

This project builds on the success of BHB in preventing sleep-related infant deaths in Baltimore City. In 2009, the Baltimore City CFR Team reviewed 27 cases of sleep-related infant deaths (often referred to as "SIDS"), documenting an alarming increase in deaths largely related to unsafe sleeping environments. Using trend data and extensive case findings and recommendations from CFR, BHB launched a multi-sector public health strategy—SLEEP SAFE—to prevent these deaths. SLEEP SAFE rallies all of Baltimore City around a single safe sleep message—*Alone. Back. Crib. Don't Smoke. No Exceptions*—and uses a multi-level framework for action:

- At the **policy** level, BHB has engaged all city birthing hospitals through a mayoral proclamation to institute standardized safe sleep education and ensure every postpartum mother views the SLEEP SAFE video. This video, the lynchpin of the SLEEP SAFE initiative, features three Baltimore City mothers telling their own stories of losing a baby due to unsafe sleep and teaching others how to prevent these tragedies.
- At the **services** level, BHB partnered with all city home visiting agencies to provide portable cribs to all eligible mothers who do not have a safe place for their babies to sleep. Through extensive outreach and collaboration with health care, social services, the justice system, and community-based organizations, BHB has trained more than 4,000 health and social service providers to deliver SLEEP SAFE messaging.
- At the **community** level, BHB's lead agencies on Baltimore's West and East sides work to change community norms for infant sleep. Teams of community health workers outreach businesses, churches, schools, and residents on safe sleep. These teams have tapped into champions such as barbershop owner Antoine Dow in the Upton/Druid Heights neighborhood, who shows the SLEEP SAFE video while his customers get haircuts.

- At the **individual** level, SLEEP SAFE mass media blasts of print materials and outdoor, radio, and television advertisements educate families on how to take personal action to keep their babies safe.

As a result of this multi-level public health strategy driven by CFR Team findings and recommendations, sleep-related infant deaths have decreased by 53%, from 27 in 2009 to 13 in 2015—the lowest recorded number of sleep-related deaths ever in Baltimore City. That translates into 61 babies saved since 2009—and 61 families who do not know the heartache of losing a child.



Sleep-Related Deaths in Baltimore City Decreased by More than Half from 2009 to 2015

Replicating this success to prevent child abuse and neglect fatalities will not be easy. However, with its reliance on data-driven CFR recommendations and coordinated action on multiple levels by a large network of public agencies and community partners, BHB's SLEEP SAFE initiative offers a proven model on which to build a strategy for keeping infants and young children safe and achieving meaningful, population-level reductions in child abuse and neglect.

d. Context: National and State Activity

The work of Baltimore City CFR to tackle child abuse and neglect fatalities comes at a critical time. As the CFR Team documented the disturbing increase in them, these tragic deaths have also been receiving greater attention at the federal and state levels. With broad bipartisan support in 2012, President Obama signed the Protect Our Kids Act, which established the President's Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF). Over two years, 12 commissioners, six appointed by the president and six appointed by Democratic and Republican leaders of the House and Senate, studied and made recommendations on:

- The use and effectiveness of federally funded child welfare services
- Best practices for preventing child abuse and neglect fatalities
- Federal, state, and local data collection systems and how to improve them
- Mitigation of risk factors for child maltreatment
- How to prioritize prevention services for families with the greatest needs

CECANF issued its final report to the President and Congress in March 2016, proposing a comprehensive national strategy and recommendations for actions to address these challenges, including steps to be taken by the executive branch, Congress, and states.[10]

Early in 2016, CECANF presented its findings and strategy to the Maryland State Council on Child Abuse and Neglect (SCCAN), a sister initiative of the Maryland State CFR Team that makes recommendations annually to the Governor and the General Assembly on the prevention, detection, prosecution, and treatment of child abuse and neglect. SCCAN elected to focus the Council's efforts in FY 2017 on the prevention of child abuse and neglect fatalities. Taking up one of CECANF's priority recommendations, SCCAN and the State CFR Team have formed a joint Maryland Child Abuse and Neglect Fatalities (MCANF) Subcommittee to conduct a retrospective statewide review of fatalities of children under four years old to identify the number related to maltreatment and make state-level policy recommendations for prevention.

MCANF also plays a key role in a related state initiative to prevent child abuse and neglect fatalities. The Maryland Department of Human Resources (DHR) applied and was accepted to the Three Branch Institute, a leadership opportunity sponsored by the National Governors Association and the National Council of State Legislatures to bring the three branches of state government together to address pressing problems in child welfare. The 2016–2018 Institute, which kicked off in July 2016, focuses on prevention of child abuse and neglect fatalities. A coalition of stakeholders organized by

DHR is working over the next 18 months with technical assistance from the Institute to promote the findings and recommendations of SCCAN, MCANF, and local CFR teams; improve services for substance-exposed newborns at risk for maltreatment; and facilitate data sharing among agencies working to prevent child maltreatment.

Staff and members of the Baltimore City CFR Team sit on SCCAN, MCANF, and the Three Branch Institute coalition and have the opportunity to contribute the findings and recommendations of Baltimore City CFR toward state efforts. As efforts to prevent child abuse and neglect fatalities reach critical mass nationally and in Maryland, Baltimore City CFR is playing a key role in driving the prevention agenda.

e. The Project: Process and Methods

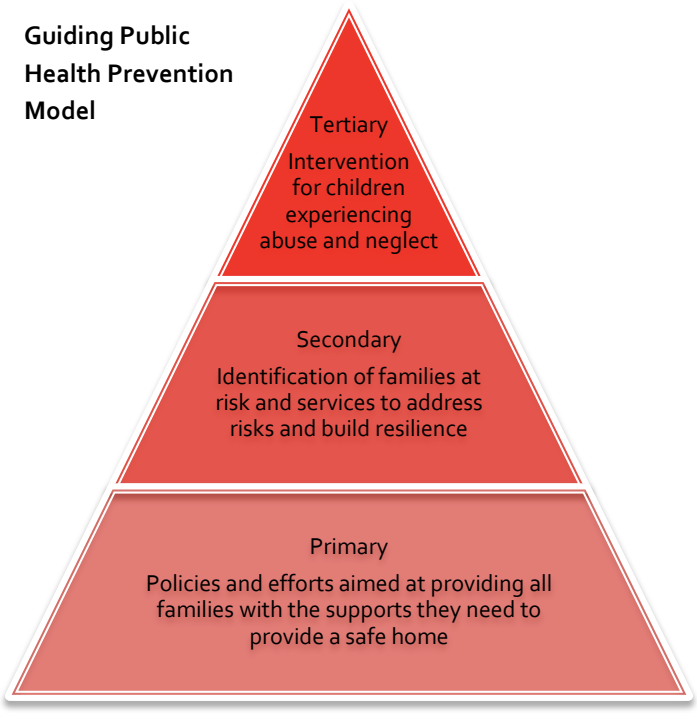
To identify trends associated with child abuse and neglect fatalities and make recommendations for prevention, Baltimore City CFR formed a Subcommittee on Child Abuse and Neglect composed of CFR staff from BCHD and CFR member representatives of the Baltimore City Department of Social Services (DSS), the Baltimore City State's Attorney's Office Special Victims Unit, HealthCare Access Maryland (HCAM), Family League of Baltimore, the University of Maryland School of Medicine, the Johns Hopkins Hospital (JHH) Pediatric Emergency Department, and the Annie E. Casey Foundation.

The subcommittee met six times from January to June 2016 to review findings from 20 cases of homicides committed from 2012 to 2015 by parents and caregivers that were referred by the OCME. The subcommittee reviewed an additional 17 cases of near-fatal child abuse and neglect, as permitted by COMAR, which provides for local CFR teams to review near-fatality cases that meet the State CFR Team's definition: "A child requiring professional health care for a life threatening event or for serious or critical condition as a result of a potentially preventable injury or illness." Near-fatality cases meeting this definition were selected from among cases presenting to the JHH Pediatric Emergency Department in 2015. Data reviewed included, when available, birth and death certificates; autopsy reports; public health records from BCHD and HCAM; health care records from hospitals, clinics, and Behavioral Health System Baltimore; child welfare records from Baltimore City DSS; law enforcement records from the Baltimore Police Department, Baltimore City State's Attorney's Office, and the Maryland Department of Juvenile Services; and education records from Baltimore City Public Schools.

During case review, the subcommittee documented risk factors and findings, with an emphasis on how systems—the health care system, the child welfare system, the social services system, the justice system—did or did not support families in accessing and utilizing critical services and meeting their needs. With a small grant from the Mayor's Office of Criminal Justice, the subcommittee engaged the University of Maryland School of Social Work to develop a database for aggregating and analyzing case data to help identify important trends in the cases, including child and caregiver demographics and risk factors.

The subcommittee then met an additional five times from July to November 2016 to synthesize the data and findings and make the recommendations for prevention presented in the following section. To inform the subcommittee's recommendations, we commissioned a review of the research literature on preventing child abuse and neglect fatalities as well as interviews of more

Guiding Public Health Prevention Model



than a dozen key local stakeholders who are engaged in child abuse and neglect prevention work. The literature review and stakeholder interviews were conducted by graduate students at the Johns Hopkins Bloomberg School of Public Health. In addition, the subcommittee carefully reviewed the recommendations released by CECANF in March 2016 and the technical assistance materials presented at the July 2016 Three Branch Institute aimed at assisting state teams in developing fatality prevention strategies.

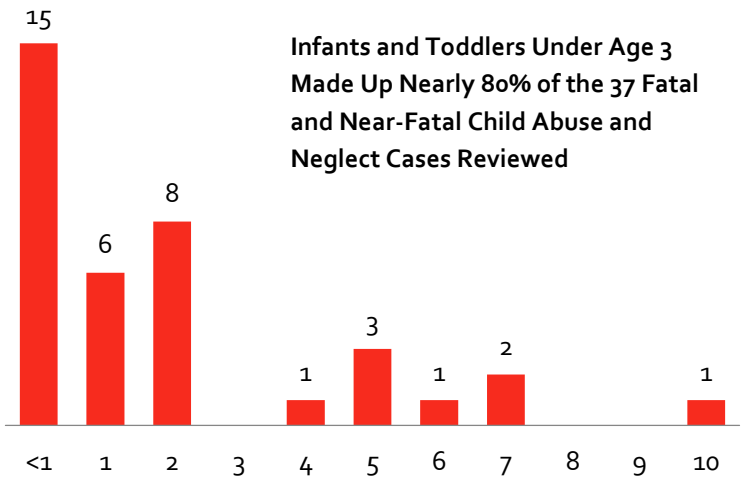
In keeping with a public health approach, while making recommendations for prevention, the subcommittee prioritized those that would achieve population-level change rather than change for a limited number of families participating in prevention programs. In particular, recommendations focused on secondary prevention strategies at the policy and services levels aimed at 1) identifying the most vulnerable families as early as possible and 2) wrapping them in a safety net of services and supports that enable caregivers to provide safe homes for their infants and children. Key recommendations also address primary prevention—strategies aimed at building resilience and preventing all families from engaging in child maltreatment—and tertiary prevention—interventions for families already engaged in the child welfare system as a result of previous abuse and neglect.

3. Key Findings and Recommendations for Prevention

The Baltimore City CFR Subcommittee on Child Abuse and Neglect documented the following major findings and made 36 corresponding recommendations for changed policies, improved services, and community education and mobilization based on its review of 37 fatal and near-fatal cases of child abuse and neglect. Recommendations that are closely aligned with or that represent a local adaptation of the CECANF recommendations released in March 2016 are indicated with a ★. A complete list of recommendations begins on page 35.

a. Highly Vulnerable Infants and Toddlers

Mirroring national statistics, victims of severe and fatal abuse and neglect in Baltimore City are disproportionately infants and toddlers—90% of child abuse and neglect fatality victims since 2012 have been under the age of 3. Completely dependent on their parents and caregivers for survival and unable to defend themselves from harm, infants and toddlers are most vulnerable to severe maltreatment.

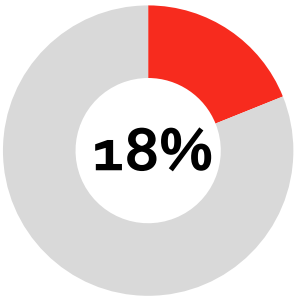


Infants and Toddlers Under Age 3 Made Up Nearly 80% of the 37 Fatal and Near-Fatal Child Abuse and Neglect Cases Reviewed

Further, infants and toddlers who are born prematurely or with low birth weight may present parenting challenges and are considered to be even more vulnerable to abuse and neglect.[11] In nine of 37 cases reviewed (24%), the child was found to have been referred as an infant to the Baltimore Infants and Toddlers Program (BITP), which provides early intervention services to infants and young children with developmental delays and disabilities. Some had spent time in the neonatal intensive care unit (NICU) due to prematurity, neonatal abstinence syndrome, and other health challenges.

Lack of Identification of Risk and Chronic Abuse

The subcommittee's starkest finding was that, despite the vulnerabilities of these young children, their caregivers had largely not been identified as at-risk for abuse or as already having engaged in chronic abuse, even though other family members and even service providers, neighbors, and acquaintances were often found to have known about the abuse and not reported it. In fact, only seven of the 37 children (18%) had been the subject of a CPS investigation in Maryland prior to the fatal or near-fatal incident.



Only 18% of Children Were Known to CPS Prior to the Fatal or Near-Fatal Incident

However, it is important to note that this number likely does not accurately reflect the actual number of children subject to a prior CPS report. Until October 1, 2016, Maryland law required all records of CPS reports that were "screened out" by the local DSS and not investigated, as well as all records of investigations in which abuse and neglect was ruled out, to be expunged within 120 days. Nationally, at least half of children who die of abuse and neglect are

known to CPS prior to their deaths.[12] Some of the discrepancy between Baltimore City and national statistics is likely due to the previous CPS record expungement policy. Some of the discrepancy may also stem from a longstanding "stop-snitching" culture in Baltimore City that leads residents not to report wrongdoing by others for fear of retaliation.

The low number of children previously known to CPS in Baltimore City is concerning, however, because research shows that a prior report to CPS—regardless of whether it is screened in for investigation or whether investigation results in a finding of substantiated abuse or neglect—is the single strongest predictor of a child's risk for injury death (intentional or unintentional) before age 5.[13] Every CPS report for an infant or toddler should be carefully screened for risk for fatality, and all CPS reports for children under age 3 should receive a response. This response could be an opened CPS investigation for moderate and high risk reports; an "alternative response" focused on assessment and provision of prevention and intervention services, as implemented in Maryland for CPS reports that are screened in but deemed to be of lower risk; or even a public health response of an offer of prevention services for the lowest risk reports. Treating CPS reports of infants and toddlers differently—screening in all reports, responding to all infant reports within 24 hours, and ensuring reviews of reports by medical experts—is one of CECANF's priority recommendations for child welfare agencies for fatality prevention.

A prior report to CPS, regardless of its disposition, is the single strongest predictor of a child's risk for injury death

While CECANF considers screening in all CPS reports for infants and toddlers to be best practice, there may be concern that doing so would lead some families to be inappropriately involved in the child welfare system, even if the "alternative response" option was used for lower risk reports and no investigation is opened. Predictive analytics tools could instead be used to systematically predict the risk level of CPS reports and determine whether the report should be screened in or out. CECANF spotlights the use of predictive analytics tools such as the Eckerd Rapid Safety Feedback Approach, which has been used in multiple components of the Hillsborough County, Florida child welfare system to prevent fatalities. As highlighted by the Three Branch Institute, robust predictive analytics tools are used to prevent fatalities in Pittsburgh, Pennsylvania to reduce errors of decision making in the CPS screening process. Evaluating use of a similarly robust tool in Baltimore City to ensure that CPS reports of infants and toddlers are fully screened for fatality risk and improve screening decisions is a strong step toward instituting an effective differential response for Baltimore City's infants and toddlers.

Improving Identification of Abuse and Neglect in Health Care

The health care system is a critical avenue for identifying abuse and neglect in young children

Frequently, as these infants and young children are not yet in school, the only system with "eyes" on them is the health care system—primarily pediatricians, emergency department (ED) physicians and staff, and Medicaid managed care organizations (MCOs) responsible for coordinating their care. The health care system is an absolutely critical avenue for identification of abuse and neglect in a child or common risk factors for abuse and neglect in the child's caregivers.[14,15]

However, case review revealed multiple missed opportunities by the health care system for identification and reporting of abuse and neglect. For example, in a case in which a 2-year-old died of multiple injuries at the hands of her mother's boyfriend, it was found that the child had been taken to three different EDs in the previous nine months for suspicious injuries. Only one of the EDs followed best practice guidelines for testing to diagnose abuse and reported the injury to CPS. None were able to identify the "ED hopping" in which her caregivers were engaging to avoid detection. Pediatricians and ED physicians and staff need ongoing training and access to tools and consultation services to support accurate identification of abuse and neglect when children present with injuries or conditions such as malnutrition. The Chesapeake Regional Information System for Our Patients (CRISP), Maryland's health information exchange, could also be configured to help identify patterns of child ED visits that are suspicious of abuse and neglect for follow up by pediatricians.

Pediatricians in particular play a critical role in preventing child abuse and neglect fatalities. As discussed further in Section 3c, caregiver factors, including substance use, poor mental health, and intimate partner violence (IPV), put children at higher risk for abuse and neglect fatality. Screening caregivers for risk factors at well-child visits and offering referrals to supportive services has been proven to reduce abuse and neglect and improve pediatric care.[16] The Safe Environment for Every Kid (SEEK) model for screening and intervening with caregivers has been endorsed by Maryland Healthy Kids, Maryland's Medicaid program for children, for use during the health and developmental history updated at each well-child visit.[17] It is also recommended by *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents,* the gold standard for pediatric care published by the American Academy of Pediatrics.[18] However, the model has not yet been widely adopted by pediatricians in Baltimore City, and pediatricians may not know where to refer families when risk factors are identified. Scaling up this model citywide has the potential to substantially improve identification and reduce maltreatment.

Screening caregivers during pediatric well-child visits is proven to reduce abuse and neglect

Although most children in cases reviewed were found to receive at least some well-child care—underscoring the need to utilize well-child care for screening and intervening early with caregivers—several children were found to have missed multiple well-child visits. Inadequate pediatric care is a red flag for abuse and neglect. In Maryland, Medicaid MCOs are responsible for ensuring that children under age 2 receive well-child care and for utilizing local health departments' Administrative Care Coordination Units (ACCUs) to outreach families with two consecutive missed visits and link them back into care. It was found that MCOs rarely contacted Baltimore City's ACCU, operated by HCAM, to initiate outreach for missed visits in the cases reviewed. Adhering to existing regulations for ensuring that well-child care happens on schedule would support increased identification of abuse and neglect during well-child visits and ensure that no child at risk goes ignored by the health care system.

Increasing Everyone's Accountability for Reporting to CPS

All early childhood services providers, including health care providers, early intervention providers, WIC staff, child welfare workers, and child care providers should be trained to better understand the risk factors for child abuse and neglect fatalities and report abuse and neglect to CPS. In line with best practices, these and other mandated reporters should be required to receive training on reporting to CPS to maintain licensure in their fields. That training should include recognizing risk for fatality among infants and toddlers; Maryland's current educational campaign on mandatory reporting does not specifically address this young population despite that they are at highest risk of death.

Everyone in Maryland is obligated under the law to report suspected child abuse and neglect

Maryland's mandatory reporting law does make clear that everyone in the community is responsible for reporting child abuse and neglect. However, in nine of 37 cases reviewed (24%), it was documented that family members disclosed to investigators after the fatal or near-fatal incident having known about prior abuse or neglect of the child but not reporting it to CPS. Building a culture of community accountability for child well-being in Baltimore City is a long-term strategy for ensuring that abuse and neglect comes to the attention of CPS. Campaigns such as the Not One More Child campaign in El Paso, Texas can raise awareness of abuse and neglect fatalities and build trust among community residents and public agencies to increase reporting.

Limited Scope of Existing Laws to Identify Risk and Prevent Infant Fatalities

Two existing Maryland laws intended to prevent fatalities of vulnerable infants were found to be too limited in scope to fulfill their purpose. Amendments to both laws would strengthen child protection. In one of the fatality cases reviewed in which a 9-day-old died of injuries and malnutrition, the infant's parents could have utilized Maryland's Safe Haven law to voluntarily and anonymously relinquish the infant to a hospital or police station without legal repercussions. However, it is

highly likely that the parents did not know about this option; the law and safe haven locations have received very little promotion and have been formally utilized only three times in Baltimore City since the law's enactment in 2007.[19] In addition, Maryland's law is considered to be inadequate for fatality prevention because it applies only to infants under 10 days old rather than to infants under 1 year old, as is considered emerging best practice.[20]

Expanding Birth Match presents a critical opportunity to identify newborns at high risk for fatality

In 2009, Maryland also enacted a Birth Match law to identify and protect newborns at high risk of fatality. Through Birth Match, parents identified on birth certificates for newborns are weekly matched against a list of parents with an involuntary termination of parental rights (TPR) by the courts within the previous 5 years. Matched parents receive a safety assessment by the local DSS, which may offer prevention services and could decide to open a CPS investigation if warranted. Although a major step forward when enacted, the law's structure and narrow scope diminish its effectiveness. If a child dies in the custody of a caregiver, the courts do not pursue termination of the parental rights of that caregiver. As a result, if that caregiver has another child, he or she will not be matched. For example, in one case reviewed, a 2-year-old died of severe neglect by his mother. Less than a year later, this mother gave birth to a new baby. Because there was no TPR, the mother was not identified by Birth Match despite that she was under investigation for homicide of her 2-year-old and that her other children had been placed in foster care pending the investigation. The new baby was seriously injured at 2 months old.

Further, under the current Birth Match law, if the caregiver culpable in a child's death was not the child's biological or adoptive parent, parental rights cannot be terminated. In another case reviewed, a father drowned his newborn son after serving 5 years in prison for killing the child of his previous partner. As a result of this loophole, he was not matched, and the birth of his son, who was clearly at very high risk of fatality, did not come to the attention of Baltimore City DSS. In addition, parents who do not respond to the court's notification of a pending TPR for a child who has been placed in foster or other out-of-home care are considered to be voluntarily relinquishing their rights. They also do not match, again despite the high risk to these parents' newborns. Amendments must be made to close these gaps.

Identifying and Monitoring Risks Over Time

To improve the ability of providers in health, child welfare, and other systems to identify risks of abuse and neglect for infants and toddlers, we must continue to collect and analyze data and use the findings to inform policy and services initiatives to prevent child fatalities. The continued efforts of Baltimore City CFR to review cases and monitor risk factors are critical. Through Baltimore City CFR, aggregate de-identified data can be regularly disseminated to health and social service providers and the community at large. In addition, analyses that link multiple sources of local population-based data, such as birth and death records, to child welfare outcomes data can enable our systems to identify patterns and intervene earlier to protect children.[21] Such data could be used effectively to better target prevention and intervention services to the families most in need, such as the home visiting services described in Section 3b.

RECOMMENDATIONS

NO.	RECOMMENDATION	LEVEL	CECANF
1	Implement a differential response by the child welfare system for infants and toddlers		★
1.1	Implement predictive analytics model for screening CPS reports based on risk for severe and fatal maltreatment for all infants and children under 3 years old	Policy	
1.2	Train CPS screeners on identifying specific risk factors for fatality to aid in decision making	Services	
1.3	Respond to all screened in CPS reports of infants under 1 year old within 24 hours	Policy	★

NO.	RECOMMENDATION	LEVEL	CECANF
1.4	Explore the development of a public health response for all infants and toddlers who have been the subject of a CPS report that has been screened out	Policy	
1.5	Develop a system for ensuring all CPS reports for infants and children under 3 years old are reviewed by a health care provider with expertise in identifying child abuse and neglect	Policy	★
1.6	Increase the frequency of visits for children under 3 years old served by the child welfare system	Policy	★
1.7	Provide specialized training for child welfare workers and court personnel on the needs of infants and toddlers and availability of local service systems for prevention and intervention	Services	
2	Improve identification of risk for abuse and neglect and chronic abuse and neglect by the health care system		★
2.1	Obtain a waiver to provide reimbursement to primary care providers for caregiver risk-factor screening through Maryland Medicaid's Healthy Kids Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program	Policy	★
2.2	Implement the evidence-based SEEK model in pediatric practices citywide to increase screening caregivers for risk factors for child abuse and neglect, providing education, and referring to community services	Services	
2.3	Create a central repository of local prevention resources and services for pediatric practices to reference for referrals when caregivers screen positive for risk factors for abuse and neglect	Services	
2.4	Train ED physicians and pediatricians to use standardized tools for evaluation and documentation of child abuse and neglect	Services	
2.5	Create a consultation service that enables ED physicians and pediatricians to access telephone consultation and medical record review by child abuse experts in Maryland's Child Abuse Medical Professionals (CHAMP) network and/or the Baltimore Citywide Child Protection Team (BCCPT)	Services	
2.6	Create an automated system using CRISP, the regional health information exchange, to flag potential cases of child abuse and neglect in which medical care has been sought for review by ED physicians and pediatricians	Services	★
2.7	Provide pediatricians with real-time access via CRISP to Maryland Prenatal Risk Assessment (MPRA) and Postpartum Infant and Maternal Referral (PIMR) forms from the child's mother's obstetric care records	Services	
2.8	Enforce regulations requiring MCOs to identify, outreach, and link back into care children under age 2 who are not receiving well-child care according to Maryland Medicaid's Healthy Kids EPSDT schedule	Policy	
3	Increase accountability for reporting to CPS by professionals, family members, and bystanders		★
3.1	Train child welfare workers, home visitors, Medicaid care coordination associates, early intervention services providers, WIC staff, and child care providers on recognizing risk factors for severe and fatal abuse and screening caregivers for risk factors	Services	
3.2	Improve existing Maryland training programs for mandatory reporters of abuse and neglect by including the specific signs and risk factors for abuse and neglect of infants and toddlers	Services	
3.3	Require training on reporting for mandatory reporters who need to maintain licenses in their fields	Policy	★
3.4	Launch a public social marketing campaign based on formative research to increase reporting of child abuse and neglect by community residents	Community	
4	Amend Maryland's Save Haven law to protect all infants from abuse and fatality		★
4.1	Extend the maximum age at which an infant can be voluntarily relinquished from 10 days to 1 year	Policy	★
4.2	Mandate community promotion of the law, including signage at all safe haven sites	Community	★
5	Amend Maryland's Birth Match law to improve identification of newborns at high risk of fatality		★
5.1	Require courts to terminate the parental rights of parents culpable in the death of their children to ensure that these parents are identified by Birth Match if they have subsequent children	Policy	
5.2	Match parents who have not contested the child welfare system's decision to seek termination of their parental rights (excluding parents who are the initiators of voluntary adoption processes for their children)	Policy	
5.3	Match parents who have a previous criminal conviction of abuse and neglect, including child homicide	Policy	
5.4	Extend the matching timeframe from the previous 5 years to the previous 20 years	Policy	
6	Utilize multiple sources of local data to monitor risks over time to inform policy and services initiatives		★

NO.	RECOMMENDATION	LEVEL	CECANF
6.1	Link data from Baltimore City vital records, MPRAs, and other records to administrative child welfare data to identify early risk factors that predict child abuse and neglect and inform targeting of services	Policy	
6.2	Maintain and publicly disseminate a detailed profile of risk and protective factors in child abuse and neglect fatality cases utilizing data gathered through Baltimore City CFR	Policy	

See also recommendations in Section 3b on health care provider referrals for pregnant women infants, Section 3d on abuse prevention and education for infants and toddlers in health care settings, and Section 3e on collaboration and data sharing among agencies serving infants and young children.

b. Challenges in the Centralized Intake System for Pregnant Women and Infants

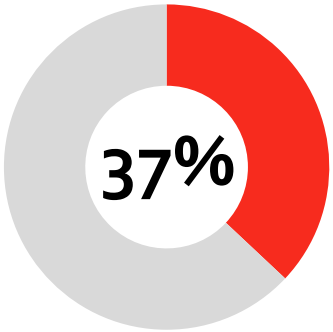
In Baltimore City, HCAM operates a centralized intake system for all pregnant women and infants who are recipients of or eligible for Medicaid. This system is the single point of entry for critical health and community-based services, including prenatal and early childhood home visiting, mental health care, substance use disorder treatment, smoking cessation programs, and WIC. Baltimore City prenatal and early childhood home visiting services include the evidence-based Nurse-Family Partnership (NFP) and Healthy Families America (HFA) home visiting programs, which are widely considered frontline prevention strategies for child abuse and neglect.[22,23] Baltimore City's coordinated home visiting system offers NFP citywide for first-time mothers who are under age 24 and HFA citywide for all other mothers who qualify based on presence of risk factors (e.g., high-risk medical condition, substance use, previous CPS involvement).

Evidence-based home visiting is a frontline strategy for preventing child abuse and neglect

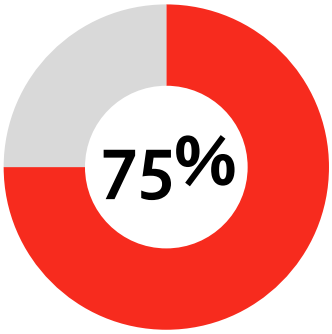
Pregnant women are referred to the centralized intake system through their prenatal care providers. These providers are required by Maryland Medicaid regulations to submit an MPRA to HCAM for each pregnant woman at her first prenatal care visit. Nurses, social workers, and associates in HCAM's Care Coordination Program (CCP) then outreach each woman, further assess her needs for care and eligibility for community services, and then link her to these services. Mothers and infants may additionally be outreached and referred following delivery; birthing hospitals are required by state regulations to submit a PIMR at postpartum discharge when mothers who are recipients of Medicaid have psychosocial risk factors (e.g., limited or no prenatal care, mental health disorder, teen mother) and/or deliver infants who are born at low birth weight or have had a stay in the NICU. HCAM may also receive administrative referrals when a pregnant woman or infant is newly added to the state's Medicaid rolls.

Low Referral, Engagement, and Enrollment Rates

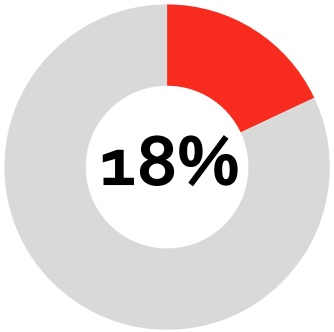
For the 29 of 37 cases reviewed in which the child was under the age of 3, the subcommittee closely examined mothers and infants' path through the centralized intake system and utilization of home visiting services. In 28 of these 29 cases, mothers were determined to be Medicaid recipients and were therefore eligible for referral to the centralized intake system. In 27 of these 28 cases, mothers had obtained prenatal care and therefore were required to have received an MPRA at their first prenatal care visit. However, only 17 received an MPRA, a completion rate of only 63% compared with an annual rate of 85-90% for all pregnant Baltimore City Medicaid recipients. Two additional pregnant women received administrative referrals, for a total of 19 referred during pregnancy. Following delivery, seven mothers received a PIMR (four of whom had previously received an MPRA), a referrals rate of only 25% despite that mothers or infants in all cases reviewed qualified for the PIMR. There was one additional administrative referral postpartum. All told, 23 of 28 mothers (82%) received some form of referral to the centralized intake system.



Did Not Receive the Required MPRA Referral

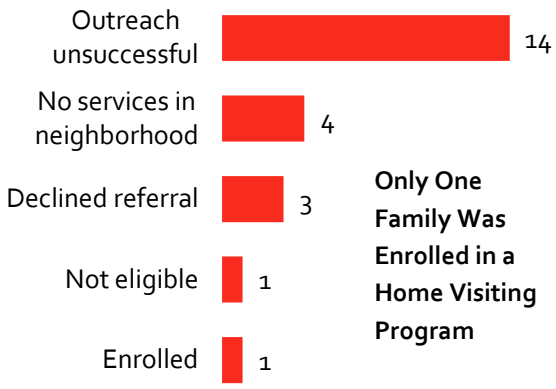


Did Not Receive the Required PIMR Referral



Did Not Receive Any Referral Despite Eligibility

Of the 23 mothers referred to the centralized intake system, only one ultimately enrolled in a home visiting program, and she was lost to follow up by the program after only a few months. Of the remaining 22 mothers, 10 were unable to be located by HCAM CCP staff when they attempted outreach after receiving the referral. One additional mother was reached by phone but refused to talk to HCAM CCP staff. Eight mothers were successfully engaged by HCAM CCP staff but did not receive a referral to home visiting services—for four, there was no home visiting offered in their neighborhoods at that time (services have been available citywide only since late 2014); three declined a home visiting referral; and one was not eligible for home visiting because her infant had been placed in foster care. Three other mothers were successfully engaged by HCAM CCP staff and accepted a referral to home visiting services, but they were unable to be located or refused to talk when the home visiting program followed up on the referral.



Only One Family Was Enrolled in a Home Visiting Program

These results indicate that mothers of children who later experience fatal or near-fatal abuse and neglect may be less likely to have received mandated MPRA and PIMR referrals and linkage to community services. And when referrals are received, these mothers also may be especially challenging to locate through outreach and engage in further assessment and services. In 14 of 23 cases (61%) in which a referral to the centralized intake system was received, the referral ultimately resulted in a mother who was unable to be located or who refused to talk; this compares with approximately 20% of referrals ending in these outcomes for all pregnant women and mothers using Medicaid outreached by the HCAM CCP. Baltimore City's home visiting programs may indeed be effective in preventing abuse and neglect, but these families largely did not have the opportunity to participate in these services.

Expanding Existing Efforts to Optimize Centralized Intake and Home Visiting Enrollment

Key CECANF recommendations revolve around making home visiting services available to families and prioritizing access to services for families at highest risk. As documented by the Pew Charitable Trusts, Baltimore City is ahead of the curve, with its coordinated home visiting system a national model and having implemented the centralized intake process, citywide access to evidence-based home visiting models, and risk-based eligibility for enrollment in its limited slots.[24] Following ongoing findings and recommendations from Baltimore City CFR, several projects have been long underway to improve the centralized intake system, starting with extensive outreach to prenatal care and hospital providers to improve completion rates for MPRAs and PIMRs and efforts to streamline completion and submission processes.

Following a successful pilot project, HCAM obtained a grant to hire pregnancy engagement specialists, who use creative tactics and a nonjudgmental approach and work outside of otherwise strict timelines to improve engagement of hard-to-reach pregnant women and mothers. Women who are unable to be located during outreach often have recently disconnected cell phones or unstable housing; they may also be avoiding contact as a result of distrust, sometimes believing that the outreach worker is affiliated with CPS, or fear of being stigmatized as a result of experiencing, for example, a substance use or mental health disorder. By building trusting relationships with neighbors, homeless shelters, detention centers, and health care providers, the specialists have been able to find more referred women and link them to services. A larger pregnancy engagement specialist workforce and sustainable funds are needed to support this work.

Struggles with family engagement were found to affect all arms of the early childhood service system, including early intervention, child welfare, and pediatric care. The Fussy Baby Network FAN (Facilitating Attuned iNteractions) approach, a national model for improving engagement and enrollment and retention in services,[25] is being used successfully in Maryland's Project LAUNCH initiative to improve early childhood services as a proven strategy for tackling a challenge that blunts the effectiveness of so many critical services for families. Building local capacity to implement the FAN approach across Baltimore City's early childhood services offers a system-changing opportunity for families and providers.

RECOMMENDATIONS

NO.	RECOMMENDATION	LEVEL	CECANF
7	Increase prenatal care providers' timely completion and submission of MPRAs per state policy		
7.1	Develop a system to be used by Maryland's Medicaid program to generate a regularly updated list of all prenatal care providers serving Medicaid recipients and their MPRA completion rates for purposes of conducting ongoing provider education on MPRA procedures	Services	
7.2	Create scorecards that provide feedback to individual prenatal care providers on their MPRA completion rates	Services	
7.3	Complete the pilot project currently underway to embed the MPRA in electronic health records and scale up implementation to prenatal care providers citywide	Policy	
7.4	Provide technical assistance to prenatal care providers in designing optimal clinic flow to support MPRA completion	Services	
7.5	Engage community-based organizations and community residents in understanding a pregnant Medicaid recipient's right to an MPRA and linkage to services to generate demand for MPRAs	Community	
8	Increase birthing hospitals' timely completion and submission of PIMRs per state policy		
8.1	Streamline the PIMR form and completion process in partnership with the Maryland Department of Health and Mental Hygiene and train birthing hospitals on revised procedures	Policy	
8.2	Regularly convene social workers in labor and delivery units and NICUs in all Baltimore-area birthing hospitals to troubleshoot PIMR completion processes and review submission rates	Services	
9	Increase use of creative engagement strategies to reach hard-to-reach pregnant women and families		
9.1	Identify sustainable sources of funding for HCAM's pregnancy engagement specialists and for increased engagement staff	Policy	
9.2	Provide city home visiting programs with access to pregnancy engagement specialists to assist in outreach for enrollment after a referral has been received	Services	
9.3	Develop and implement models of peer-based outreach and engagement, particularly when working with pregnant women and families that are members of stigmatized groups (e.g., substance users)	Services	
9.4	Rebrand home visiting services using top-down and grassroots strategies to dispel myths and misperceptions and generate demand for services	Community	
9.5	Continue the existing collaboration with the Johns Hopkins University School of Nursing to understand the strengths and needs of hard-to-reach pregnant women to inform creative engagement strategies	Services	
10	Eliminate administrative barriers to enrolling pregnant women and families in home visiting services		

NO.	RECOMMENDATION	LEVEL	CECANF
10.1	Eliminate perceived barriers to referring and enrolling high-risk mothers and infants following delivery (as opposed to during pregnancy) by city home visiting programs	Policy	
10.2	Streamline processes to expedite the enrollment of teen mothers in foster care in home visiting services	Policy	★
10.3	Develop and implement procedures to enable the enrollment in home visiting of infants placed into kin care by the child welfare system	Policy	
11	Implement a common systematic approach to strengthening engagement across early childhood services		
11.1	Train local trainers on the Fussy Baby Network FAN approach to family engagement, a national model for operationalizing trauma-informed care and improving family engagement, to build a sustainable model for implementation citywide	Services	
11.2	Train and implement the FAN approach with HCAM CCP staff and home visiting providers, evaluating changes in rates of initial engagement and enrollment and of program retention	Services	
11.3	Scale up implementation of the FAN approach over time in WIC, BITP, child care programs, the child welfare system, and pediatric practices	Services	
12	Continue to build a prenatal care-to-kindergarten pipeline to avoid missed opportunities for intervention		
12.1	Identify sustainable, non-Medicaid sources of funding to ensure the HCAM CCP can provide pregnant women and infants with assessment and linkage to non-Medicaid community services and supports	Policy	
12.2	Continue to streamline referral processes and offer priority enrollment from home visiting to Head Start and from Head Start to Pre-K, where families will receive continued risk screening and supports	Services	

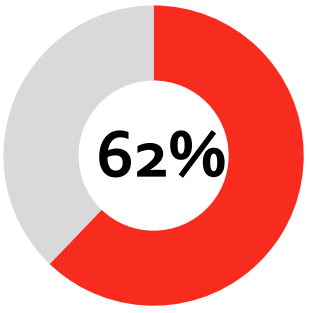
c. Perfect Storm of Caregiver Risk Factors

Research has found an association among several caregiver factors and child abuse and neglect, and these same risk factors were prevalent among the 37 cases reviewed, including caregiver substance use, maternal mental health disorder, non-relative male caregivers in the home, IPV, and lack of safe child care options.[26] In most cases, families were experiencing multiple risk factors that, when combined, made for a dangerous environment for the child.

Substance Use

Caregiver use of illicit substances emerged as a significant trend among the cases reviewed. Based on records of treatment for substance use in Maryland's public behavioral health treatment system and law enforcement records, caregivers of children in 23 of the 37 cases reviewed (62%) used illicit substances. In 10 cases substance use was documented for both the mother and father, in nine cases for the father only, and in four cases for the mother only. Caregivers who had not sought treatment for substance use disorder, caregivers who sought only private treatment, and/or caregivers who had not been charged criminally for substance use were not able to be identified; therefore, the number of caregivers using illicit substances documented through review is likely to be an undercount.

More Than Half of Children Lived with at Least One Caregiver Who Used Illicit Substances



It is estimated that about 12% of children in the United States live with a parent who uses substances[27] and that about 61% of infants and 41% of older children placed in foster or other out-of-home care are from families with caregivers engaged in active alcohol or drug use.[28] A parent's substance use disorder may affect his or her ability to function effectively as a caregiver for a variety of reasons, including physical or mental impairments caused by alcohol or drugs and already limited time and funds spent on seeking alcohol and drugs rather than spent on time with the child or purchasing food or other household necessities. Substance use can also lead to reduced capacity to respond to a child's cues and needs, difficulty regulating emotions and controlling anger and impulsive reactions to stressors, and

disruptions in attachment between parent and child. Family life may be unpredictable and chaotic, and if the caregiver's substance use leads to estrangement from family and friends, there may be few social supports for the child and family in times of need.[29]

Infants born exposed to substances in utero (substance-exposed newborns [SENs]) may also present challenges to parents. Infants with neonatal withdrawal or abstinence syndrome may have increased irritability, high-pitched crying, and feeding problems and can require long NICU stays. Infants with fetal alcohol spectrum disorder may have motor abnormalities and developmental delays.[30] Six of the 37 children reviewed (16%) were confirmed to have been SENs. This is also likely an undercount, as laws relating to screening and reporting SENs changed in 2013 and there still exist many inconsistencies in toxicology testing and reporting across birthing hospitals that must be addressed. In the cases of SENs, continued caregiver substance use often played a significant role in the fatal or near-fatal incident. For example, a 2-year-old who had been removed from her mother's care at birth had been placed in her father's custody. While under the influence of alcohol, he left her in a car alone where she died of hyperthermia. In another case, a 2-month-old SEN nearly died of intoxication of her mother's unprescribed methadone. In another case, a newborn infant died of multiple injuries and malnutrition while both parents used heroin over several days.

Substance use disorder is a disease requiring treatment, not a character deficiency

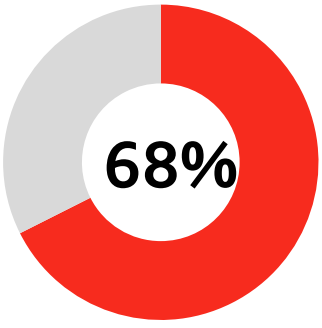
A citywide strategy for supporting caregivers of infants and young children who use substances is of critical importance to preventing child fatalities. While the above acts are abusive and egregious, few parents intend to harm their children. In reality, substance use is often a maladaptive coping strategy—self-medication—for poor mental health, stress, and trauma. Substance use disorder is a disease—not a character deficiency—that can be addressed with treatment. We must improve screening, referral, and access to substance use disorder treatment for parents in Baltimore City and ensure wide promotion of the city's 24/7 Crisis, Information & Referral Line, through which licensed counselors can assess callers and link them to appropriate care quickly, often the same day.

Innovative models of service delivery specifically for pregnant women and mothers who use opioids and other drugs exist that can be adapted for use locally. These include the Children and Recovering Mothers (CHARM) model of collaborative planning between health care providers and child welfare agencies during pregnancy to ensure plans of safe care for both mothers and infants[31] and the Newborns Exposed to Substances Support and Therapy (NESST) model of home-based therapy for mothers and young children to improve attachment and parenting.[32] With additional funding, the capacity of the city's home visiting programs can be expanded to receive increased referrals for mothers of SENs. Further, we can also support and expand existing efforts of the BHB Preventing Substance-Exposed Pregnancies (PSEP) Collaborative to improve access to family planning counseling, effective contraception, and substance use disorder treatment to girls and women of reproductive age before becoming pregnant.

Mental Health Disorders

Along with having caregivers who use substances, many children lived with a caregiver—most commonly their mother—who had a diagnosed mental health disorder. In 25 of 37 cases reviewed (68%), caregivers were determined to have a mental health disorder based on records for mental health treatment in Maryland's public behavioral health treatment system or pregnancy-related maternal health records. In five cases, a mental health disorder was documented for both the mother and father, in two cases the father only, and in 18 cases the mother only. Caregivers with mental health disorders who had not sought mental health treatment or who sought only private treatment were not able to be identified; therefore, this number, too,

More Than Half of Children Lived with at Least One Caregiver with a Mental Health Disorder



is likely to be an undercount. The most common diagnoses were depression and bipolar disorder, but anxiety disorders including posttraumatic stress disorder were also common. Less common but still identified were disorders such as schizophrenia and schizoaffective disorder.

Research has found that children of mothers with mental health disorders are twice as likely to experience abuse and neglect.[33] As with having a substance use disorder, having a mental health disorder can influence parenting behaviors that affect child safety. Depression is associated with elevated rates of coercive and hostile parenting and corporal punishment. Mothers who have anxiety disorders may be less able to demonstrate warmth and instead offer more criticism. They may also be more disengaged from their children than mothers without anxiety. Mothers with both depressive and anxiety disorders may have lower quality interactions with their children, have poorer attachment, be less sensitive to their children's needs, and experience more distress about their role as parents. Furthermore, mothers with mental health disorders may have greater difficulty negotiating the challenges of poverty experienced by nearly all of the families in cases reviewed (see Section 3f) as well as negotiating relationships marked by IPV, as described below.

Mothers with poor mental health have more difficulty negotiating challenges of poverty

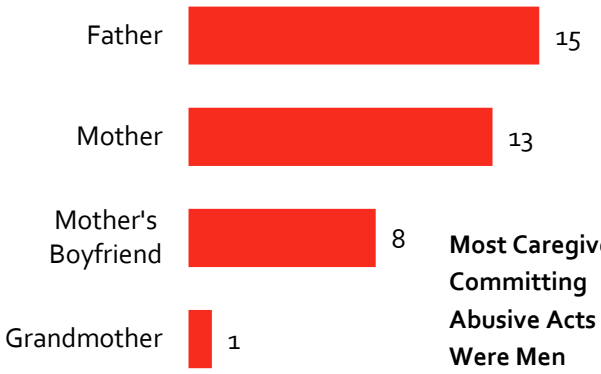
Like substance use disorders, some mental health disorders may have their roots in experiences of trauma and violence (see Section 3d for discussion of mothers' past histories as childhood victims of abuse and neglect). While many mothers were found to be accessing mental health care, they often moved from provider to provider and had major gaps without care. Women are particularly vulnerable during pregnancy, when medications may be adjusted, and during the postpartum period, when newly emerging and relapsing mood disorders are common. In December 2016, the Maryland Maternal Mental Health Task Force released recommendations for addressing maternal mental health, including through improved screening, referral, and access to treatment and advanced training of obstetric and psychiatric providers on maternal mental health. The Baltimore City Fetal-Infant Mortality Review (FIMR) Team is examining maternal mental health and will release recommendations in spring 2017 for the local system of care. Both sets of recommendations should be supported to ensure more mothers get the mental health care they need.

In addition, citywide efforts to promote secure attachment should be scaled up. Several organizations in the early childhood system have been trained to offer Circle of Security Parenting (COS-P) group-based programs; these programs should be widely accessible to all families with young children, especially for mothers with mental health disorders. Early childhood programs, including home visiting, WIC, BITP, child care providers, and pediatric practices must also have access to mental health consultation to improve infant-parent attachments and relationships. Other critical strategies to promoting strong attachment with vulnerable infants include enacting NICU policies that support attachment with newborns, especially those with conditions such as neonatal abstinence syndrome, and initiatives that encourage initiation of breastfeeding, such as the recent social marketing campaign launched by BHB. Investments in improving maternal and early childhood mental health will pay off in improved safety and survival of young children.

Promoting strong attachment can prevent abuse and neglect of young children

Male Caregivers, IPV, and Lack of Safe Child Care Options

In 23 of 37 cases reviewed (62%), the caregivers committing the abusive or neglectful act were men: 15 were the child's biological fathers, and eight were the child's mother's current or former partners, not related biologically to the child. In the 14 remaining cases, the caregivers were women: 13 were the child's biological mothers, and one was the child's paternal grandmother. In 76% of cases, therefore, the caregiver committing the abuse or neglect was the child's biological parent, comparable to 79% nationally.[34] Male caregivers committing the abuse or neglect tended to be younger, in their



early to mid-twenties, often with substance use disorders. Female caregivers tended to be older, in their early to mid-thirties, often with mental health disorders.

The number of male caregivers committing abusive and neglectful acts is a challenge to prevention and intervention services that are often geared toward serving mothers and children. While there are systematic ways to identify and assess mothers at risk, such as the previously mentioned MPRA and PIMR referrals, no such mechanism exists that systematically identifies fathers for supportive services. Fathers may also be less likely to accompany their children to well-child care, meaning they may go unscreened in pediatric offices. This is particularly the case for mothers' boyfriends who are not biologically related to the child.

The combination of a non-relative male caregiver in the home, IPV (though this was also common in cases involving biological fathers), and lack of safe child care options was a striking pattern across these cases. In one case, a mother without any other source of regular child care left for work with her toddler in the care of her boyfriend, against whom she had filed a peace order 6 weeks earlier; he had been charged with second-degree assault in an incident of IPV. The toddler died from multiple injuries resulting from beating and shaking. In another case, a mother with a long history of treatment for depression left her 1-year-old twins in the care of her ex-boyfriend, despite that they had separated due to IPV and that they had had a physical altercation earlier that day during which he had threatened to kill her and the children. She needed to visit someone in the hospital and had no other option for child care. The twins were beaten and seriously injured, with one becoming unresponsive in the ED but subsequently revived. Often in cases in which the caregiver committing the abuse or neglect was the child's biological father, the father was not the child's regular caregiver and may not have had a bonded relationship with the child. For example, in one case a young father had been in jail for assault since before his 3-month-old's birth. The day after he was released from jail, the mother left the infant in his care for the weekend. He admitted to shaking the infant until she became unresponsive when he could not get her to stop crying.

Ensuring that the early childhood service system reaches men, including non-relative male caregivers, is essential, as is collaborating with existing fatherhood initiatives in Baltimore City to support men in their role as parents. Programs and policies to improve attachment, including the COS-P groups offered in Baltimore, must make special efforts to include men, who may have less opportunity to form secure attachments with children not regularly in their care or when there are questions about paternity. In many cases, this will require a system-wide shift in thinking about outreach and service delivery.

The early childhood system must make special efforts to reach male caregivers

Collaborating with Baltimore City's IPV service providers is also critical. Research has found that mothers reporting experiencing IPV also report their child experiences abuse almost three times as often and neglect twice as often as mothers not reporting IPV.[35] The safety of mothers and children are compromised when IPV is present, and mothers may regularly be in the position of leaving their children with caregivers who are unsafe. IPV service providers and the health care system, primarily obstetric care providers, pediatricians, ED physicians and staff, and home visiting providers must screen for IPV and assess a family for child abuse and neglect and engage in safety planning when IPV is identified.

Lack of safe, quality child care must also be addressed in order to prevent child abuse and neglect fatalities. In too many cases, a child was in the care of an unsafe caregiver, whether a caregiver who was a perpetrator of IPV or previous abuse or neglect of that child, a sibling, or another child. Parents must be educated about the importance of selecting a safe

caregiver for their child. However, parents must also have access to safe, quality, affordable child care in order to make good choices for their children.

Child care subsidies with no waiting list for access decrease rates of abuse and neglect

Analyses have found that states that meet families' demand for subsidized child care (i.e., those without waiting lists) have lower rates of abuse and neglect even after controlling for factors such as poverty and caregiver education, one of only two of 31 economic policies analyzed found to impact child maltreatment.[36] Access to safe, quality child care also reduces parental stress and rates of maternal depression. Of cases reviewed, in not a single case in which the caregiver committing abuse or neglect was not the child's regular caregiver did the regular caregiver have access to subsidized child care through Maryland's Child Care Subsidy (CCS) Program. According to key stakeholders, CCS voucher reimbursement rates are extremely low, requiring parents to pay significant co-pays and additional out-of-pocket costs, severely limiting the utility of the vouchers. When not tied to a case with Baltimore City DSS, the application process is onerous and wait times are lengthy. Improving the CSS Program and offering other child care options in Baltimore City, such as emergency drop off child care and child care cooperatives, would provide safe alternatives in potentially dangerous circumstances for young children.

RECOMMENDATIONS

NO.	RECOMMENDATION	LEVEL	CECANF
13	Improve accurate and equitable identification of SENs to inform decisions about policy and services		★
13.1	Implement policies for universal toxicology testing and CPS reporting of SENs at birthing hospitals to eliminate biases and lapses in testing and reporting	Policy	
13.2	Increase birthing hospitals' submission of PIMRs for all SENs, consistent with existing state policy, to ensure they are linked to community services including home visiting	Services	
13.3	Systematically collect detailed data at Maryland DHR on hospital reports of SENs and regularly share data with local health departments to improve the ability to plan and provide services	Policy	
14	Improve access to and quality of services to mothers, SENs, and families affected by substance use		
14.1	Bring together stakeholders through the BHB PSEP Coalition to ensure that parents of children under 5, including those in kin care as a result of substance use, have access to a full range of services and supports to build resilience, improve parenting skills, and prevent maltreatment	Services	
14.2	Advocate for legislation to support collaborative planning during pregnancy between health care providers and CPS to facilitate coordinated plans of safe care for mother and baby, avoid emergency removals of SENs, and improve services to mothers and families, adapting the Children and Recovering Mothers (CHARM) Collaborative model for Baltimore City	Policy	
14.3	Provide advanced training and ongoing support to home visiting providers and other early childhood service providers on addressing the needs of caregivers who use substances and SENs	Services	
14.4	Expand the capacity of the city's HFA home visiting programs to meet the greater demand for services posed by increased referrals for families of SENs, managing the impact of services for SENs on the centralized intake system for pregnant women and infants and the coordinated home visiting system	Services	
14.5	Develop and implement an alternative to traditional home visiting programs for mothers with opioid and cocaine dependence that utilizes clinical therapy and peer-based mentoring, adapting the NESST model for Baltimore City	Services	
14.6	Involve birth parents (those in recovery who have had children removed from their care due to substance use) in designing effective child welfare programs and prevention strategies for families affected by substance use	Community	
15	Support the work of the BHB PSEP Coalition to prevent and address substance-exposed pregnancies		
15.1	Increase access to family planning services for pregnant women and women of reproductive age who are using substances	Services	

NO.	RECOMMENDATION	LEVEL	CECANF
15.2	Increase the use of the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) model in settings that serve girls and women of reproductive age	Services	
15.3	Increase access to substance use disorder treatment for girls and women who are pregnant or of reproductive age who are using substances, diversifying the range of treatment options available	Services	
15.4	Develop and implement a strategy for using peer recovery workers to conduct street outreach and encourage pregnant women using substances to seek prenatal care and treatment	Community	
15.5	Provide training to prenatal care providers to improve knowledge, attitudes, and beliefs related to pregnancy and substance use; reduce stigma; and improve quality of care	Services	
15.6	Provide training and technical assistance to prenatal care providers to increase adherence to American College of Obstetrics and Gynecology (ACOG) practice guidelines for screening pregnant and postpartum women for substance use	Services	
15.7	Develop and implement a policy advocacy strategy to prevent the development of substance use disorders in girls and women (e.g., advocating for changes to the built environment such as decreased liquor store density)	Policy	
16	Support forthcoming recommendations of Baltimore City Fetal-Infant Mortality Review (FIMR) and the Maryland Maternal Mental Health Task Force to address mental health in pregnancy and postpartum		
16.1	Provide training and technical assistance to prenatal care providers to increase adherence to ACOG practice guidelines for screening pregnant and postpartum women for mental health disorders	Services	
16.2	Provide training for prenatal care providers and psychiatric providers on the use of psychiatric medications during pregnancy and risks of discontinuing medications	Services	
16.3	Provide training for prenatal care providers and mental health providers to address maternal mental health during pregnancy and improve coordination of care	Services	
16.4	Enable prenatal care providers to access telephone consultation from psychiatric providers through an expansion of the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) model	Services	
16.5	Develop and implement a strategy for utilizing peer navigators to support women in accessing treatment for mental health disorders	Community	
16.6	Launch a public social marketing campaign to increase community awareness of maternal mental health concerns and generate demand for treatment	Community	
17	Improve access to substance use and mental health disorder treatment for all caregivers who need it		★
17.1	Make substance use and mental health screening universal for all caregivers involved in the child welfare system using a standardized tool and an evidence-based intervention model such as SBIRT	Services	
17.2	Train child welfare workers and health care providers, especially prenatal and pediatric providers, to use Baltimore City's 24/7 Crisis, Information & Referral Line to link caregivers to treatment	Services	
17.3	Launch a public social marketing campaign to heavily promote the Crisis, Information & Referral Line to raise awareness of treatment options and generate demand for treatment	Community	
18	Support healthy, secure attachment between caregivers and young children at risk		
18.1	Expand use of the Circle of Security Parenting model citywide to promote secure attachment using consistent language and intervention strategies across the early childhood system	Services	
18.2	Expand infant mental health consultation services in home visiting, WIC, BITP, child care settings, and pediatric practices	Services	★
18.3	Expand the work of BHB to train peer breastfeeding counselors and promote breastfeeding initiation and duration to improve attachment	Community	
18.4	Develop a policy at each Baltimore-area NICU for supporting attachment, particularly for infants with neonatal abstinence syndrome	Policy	
19	Increase fathers and mothers' male partners' emotional support of their children and families		
19.1	Collaborate with partners to further infuse fatherhood and male responsibility initiatives into settings with boys and men in Baltimore City	Services	
19.2	Make deliberate and special efforts to include male caregivers in attachment and parenting skills programs (e.g., Circle of Security Parenting, home visiting sessions)	Services	
20	Improve early identification of and intervention for IPV in families with young children		
20.1	Provide training and technical assistance to prenatal care providers to increase adherence to ACOG practice guidelines for screening pregnant and postpartum women for IPV	Services	

NO.	RECOMMENDATION	LEVEL	CECANF
20.2	Train prenatal care providers to use CRISP to identify injuries for which their patients have sought care that may have resulted from IPV and provide linkage to services	Services	
20.3	Increase rates of IPV screening and intervention in home visiting programs, adopting an evidence-based model of brief intervention such as the Domestic Violence Enhanced Home Visiting model	Services	
20.4	Screen women for IPV in WIC program sites	Services	
21	Provide supports to prevent child abuse and neglect when IPV has been identified		★
21.1	Collaborate with IPV service partners in Baltimore City to assess families for potential child abuse and neglect and link them to supportive services	Services	
21.2	Collaborate with legal clinics and courts hearing peace and protective order cases to link families with young children to supportive services	Services	
21.3	Provide training to ED providers on counseling and safety planning for families with young children when IPV has been identified in the ED	Services	
22	Improve access to and effectiveness of the Maryland Child Care Subsidy (CCS) Program		
22.1	Eliminate waiting lists for CCS vouchers to enable families to access safe child care, including while they are obtaining employment	Policy	
22.2	Streamline the lengthy process for obtaining CCS vouchers for families not using TANF/TCA, enabling the Baltimore City Child Care Resource and Referral Center to take applications on site rather than requiring applications be faxed	Policy	
22.3	Increase reimbursement rates for CCS vouchers to ensure the vouchers cover a greater share of child care costs and enable meaningful access to child care for low- and very low-income families	Policy	
23	Expand child care options, particularly in communities that are child care deserts		
23.1	Develop new and expand existing options for crisis, respite, and drop-in child care in Baltimore City	Services	
23.2	Collaborate with grassroots and other community-based organizations to implement child care cooperatives in which caregivers become trained child care providers and barter services	Services	
23.3	Incentivize workplaces to provide assistance with funding child care or offering on-site child care	Policy	
24	Educate mothers and families about the need to choose safe caregivers for infants and young children		
24.1	Launch a public social marketing campaign based on formative research to raise awareness of the need to vet informal child care providers and access alternative options	Community	
24.2	Offer ongoing support to legal guardians of children removed from their biological parents' care in navigating child care and family dynamics when they remain in contact with the child's parents	Services	

See also recommendations in Section 3a on screening caregivers for risk factors in pediatric practices and providing reimbursement for screening through Medicaid and Section 3d on strategies for addressing inappropriate caregiver response to child behaviors.

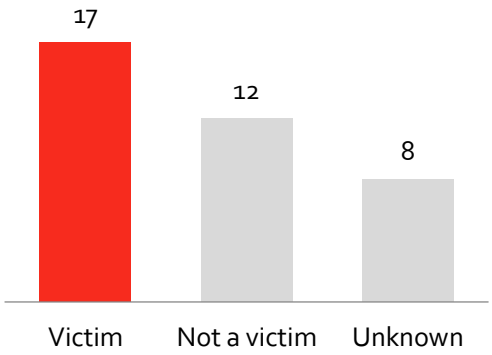
d. Family History of Child Abuse and Neglect

Caregivers often had difficulty with emotional self-regulation when challenged

The most common form of abuse and neglect in the cases reviewed was beating that resulted in multiple injuries, including head trauma. Although in most cases it remained unknown why a particular abusive incident occurred, in some cases parents and caregivers disclosed a precipitating event—the child's crying or vomiting, a diaper or toileting accident, or perceived willful misbehavior on the part of the infant or child. In many cases, the parent or caregiver's expectations for the child's behavior were not appropriate based on the child's age and developmental stage. The parents or caregivers also often seemed to be highly reactive, having difficulty regulating their own emotions and responses to child behavior, conflict with their partners, or other circumstances in the home environment. For example, in one case a mother impulsively beat a child around her head and neck, burned her with a flat iron, and put an object in her vagina to punish her after an argument. She then threatened her with further beating if she told anyone what had happened. Upon review, the subcommittee learned that this mother had a history with Baltimore City DSS as a victim

of both physical and sexual abuse as a child, starting at age 5. She subsequently repeated multiple grades, dropped out of high school, and was coping with depression and anxiety. And she was the subject of multiple prior CPS reports for abusing the child's siblings.

Almost Half of Mothers Had Been a Victim of Abuse or Neglect with Baltimore City DSS as a Child



Prior Child Welfare History of Caregivers as Children

One of the most compelling, and saddest, issues identified through case review was the number of caregivers, particularly mothers, who themselves were confirmed through records of Baltimore City DSS to have a history of abuse and neglect (one or more CPS investigations opened in which a finding of abuse or neglect was not ruled out). Seventeen of 37 mothers (46%) were confirmed to have such history, with 12 having no history as a victim and eight with unknown history. Five of 37 fathers (14%) had such history, with 16 having no history as a victim and 16 with unknown history. (History may remain unknown for multiple reasons, including that the parent's name or date of birth was not known to Baltimore City CFR, that records were too old to retrieve, and that the parent did not live in Baltimore City as a child.) At least eight mothers and one father were confirmed to have been in Baltimore City's foster care system as children. Others may have experienced abuse or neglect that went unreported to Baltimore City CPS, or was reported but not investigated, and so was expunged.

Research shows that the majority of people who experienced abuse and neglect as children do not go on to abuse and neglect their own children, but that as a whole, children of people who were abused and neglected have higher rates of abuse and neglect themselves.[37] Children whose mothers gave birth as teenagers after having been recipients of child welfare services as a child have greatly elevated experiences of child maltreatment by age 5.[38] When intergenerational abuse does occur, multiple pathways may be involved. Poor models for parenting may leave some ill-equipped to function as parents. The very coping mechanisms for or consequences of early trauma—substance use, depression, earlier initiation of sexual activity leading to teen pregnancy—are also risk factors for committing abuse and neglect. Experiences of trauma and involvement as a child with the child welfare system may further lead to understandable distrust of service systems and lack of willingness to participate in services intended to prevent abuse and promote resilience.

Understanding family history of abuse and neglect is critical to prevention efforts

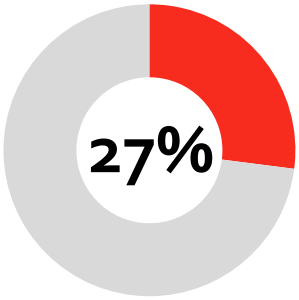
Involvement with other systems of social care is also a predictor of child maltreatment—parents who have previously been involved with juvenile justice services, for example, are also more likely to commit fatal abuse of their children than those who have not.[39] Federal child welfare legislation passed in 1997 recognizes the continuous risk of child maltreatment by those who have previously committed child fatalities or other serious forms of child maltreatment and allows for child welfare agencies to forego usual requirements to attempt to preserve the relationship between those parents and subsequent children. The same principle holds with child fatality prevention—essentially, that the information about the family's history—not just the child's—is vital to prevention. Prevention efforts must have a family focus.

Prior Child Welfare History of Caregivers as Adults

Although the child in most cases reviewed was not known to Baltimore City CPS prior to the fatal or near-fatal incident (with the caveat described in Section 3a, that screened-out reports and investigations resulting in a ruling out of abuse or neglect have been expunged, and so likely result in an undercount of children previously known to CPS), in seven of 37 cases (19%) the child was known to Baltimore City CPS through a prior investigation in which abuse or neglect was not

ruled out (two had an open case at the time of the fatal or near-fatal incident). In 10 cases (27%) at least one of the child's siblings was the subject of a prior CPS investigation in which abuse or neglect was not ruled out.

These families would have benefited from additional support from the child welfare, early childhood, and health care systems. Following some investigations, CPS cases were closed with few in-home child welfare services provided. In some cases, CPS made safety plans with the family to ensure that the child would not be left under the sole supervision of an unsafe caregiver, and these safety agreements were subsequently broken, likely as a result of lack of safe, affordable child care options (see Section 3c for discussion of child care challenges). Some families proved difficult to engage in voluntary in-home child welfare services, just as they can be difficult to engage in the city's centralized intake system for pregnant women and infants and in the home visiting system, as described in Section 3b. Outreach and offers of services by "credible messengers"—perhaps other parents involved in the child welfare system and thriving—may have the potential to engage families in services that could prevent the fatal and near-fatal tragedies that occurred in the cases reviewed.



In 1 Out of 4 Cases, One of the Child's Siblings Had a Previous CPS Investigation in Baltimore City

Supporting Families with a History of Abuse and Neglect

Regardless of previous child welfare involvement, all caregivers who desire them should have access to parenting resources, including home visiting, parenting classes, support groups, and crisis support. Stakeholders reported that many programs in Baltimore City are underutilized, including the confidential Parenting HelpLine, which provides support to parents in crisis or needing guidance 24/7 and is operated by the Family Tree, Maryland's *Prevent Child Abuse America* affiliate organization located in Baltimore City. Family Tree and Sinai Hospital are currently piloting *Maryland Family Connects,* an innovative, evidence-based model for connecting all families delivering infants at Sinai with parenting and other resources early—right after a baby is born. Monitoring this pilot and, if effective, potentially expanding the centralized intake system for pregnant women and infants to offer *Maryland Family Connects* to all families delivering infants in Baltimore has potential to improve parenting citywide. Targeted education programs to prevent inappropriate responses to child behavior (e.g., shaking or giving methadone to a crying baby) can also be implemented universally in settings such as NICUs and WIC sites.

Trauma treatment offered in Baltimore City can break intergenerational cycles of abuse

For caregivers who were themselves victims as children and have in turn committed abuse or neglect, breaking intergenerational cycles of abuse and neglect is paramount. Both children and parents involved currently involved in the child welfare system should receive priority access to the substantial range of individual, family, and group-based trauma treatment programs offered in Baltimore City. Baltimore City is fortunate to be the home of the Family-Informed Trauma Treatment Center, a collaboration of the University of Maryland Schools of Medicine and Social Work and the Family Center at the Kennedy Krieger Institute, as well as numerous professionals trained to provide treatment.

Children and youth in the foster care system particularly must have access to trauma treatment and a full array of supports, including those already offered through Maryland's Ready by 21 initiative. Those youth in foster care who are pregnant and parenting need priority, streamlined access to home visiting and other services to help them provide safe, stable, and nurturing environments for their children. For families with active CPS and other child welfare cases, in addition to providing parenting skills programs, CECANF also recommends utilizing predictive analytic tools or augmented administrative review processes to identify child welfare cases that may lack the necessary service components or have inadequate staff support to address the risks of severe or fatal maltreatment.

A long-term but critical broad primary prevention strategy is working in early childhood programs such as center-based child care, Head Start, and pre-K and in schools to promote social-emotional development in all children. By fully scaling up initiatives including Maryland's Social and Emotional Foundations of Early Learning (SEFEL) in early childhood settings and other positive behavioral interventions and supports programs, as well as mindfulness programming, in schools, children can learn emotional self-regulation and positive ways to respond, rather than react, in highly stressful situations. Children who build these skills can remain resilient in the face of life's adversities and are well positioned as they grow and develop into young adults who become caregivers themselves.

Early childhood and school-based social-emotional programs offer strong primary prevention

RECOMMENDATIONS

NO.	RECOMMENDATION	LEVEL	CECANF
25	Fully landscape and support existing effective parenting support resources in Baltimore City		
25.1	Monitor implementation of NFP home visiting with first-time mothers under age 24, expanding if demand exceeds present capacity	Services	
25.2	Monitor the Family Tree pilot of the evidence-based *Maryland Family Connects* short-term home visiting program, collaborating to expand the model citywide if effective	Services	
25.3	Landscape parent support programs (e.g., Chicago Parent Program, Parent University, Incredible Years) available in Baltimore City and facilitate referrals by a wide range of providers	Services	
25.4	Expand social marketing for the Family Tree 24/7 Parenting HelpLine to increase utilization, with special attention to reaching male caregivers	Community	
26	Implement targeted education programs to prevent inappropriate responses to child behavior		
26.1	Incorporate education prenatally and postpartum on preventing abusive head trauma, responding to infant and child crying, and managing other child behaviors in home visiting, at postpartum discharge, and at WIC program sites	Services	
26.2	Educate parents with infants in the NICU about increased risk of abuse and strategies for addressing behavioral concerns that may accompany the infant's medical conditions	Services	
26.3	Educate all clients of behavioral health treatment providers about the importance of keeping methadone and other medications away from infants and children and not using them to quell crying	Services	
27	Provide intensive treatment and supports for children and caregivers involved in the child welfare system		★
27.1	Increase access to and utilization of the substantial individual and family trauma treatment services in Baltimore City (e.g., trauma-focused cognitive behavioral therapy, Strengthening Family Coping Resources, Parent-Child Interaction Therapy)	Services	
27.2	Provide intensive supports across a range of concerns (e.g., mental health, financial, parenting) to youth in foster care, especially youth who are pregnant and parenting	Services	★
27.3	Include history in foster care or as a victim of abuse or neglect in the criteria for prioritizing pregnant women and mothers for city home visiting services	Policy	
27.4	Continue to train and support child welfare workers, home visitors, and early childhood service providers in adopting trauma-informed care	Services	
28	Ensure adequate supports are provided to families with active child welfare cases		★
28.1	Continue and expand offerings of behavioral parent training programs to caregivers	Services	★
28.2	Consider the adoption of predictive analytic tools or augmented administrative review processes to identify child welfare cases that may lack the necessary service components or have inadequate staff support to address the risks of severe or fatal maltreatment	Policy	★
29	Intervene in childhood to support these future caregivers in developing emotional self-regulation		
29.1	Support and expand early childhood initiatives that teach foundational social-emotional skills and promote emotional self-regulation, such as Maryland's Social and Emotional Foundations of Early Learning (SEFEL) project	Services	

NO.	RECOMMENDATION	LEVEL	CECANF
29.2	Support and expand school-based initiatives to increase social-emotional competence and promote emotional self-regulation, such as Positive Behavioral Interventions and Support, mindfulness training, and social skills teaching	Services	
29.3	Support work by SCCAN to implement the CDC's Essentials for Childhood framework for preventing adverse childhood experiences, improving the social-emotional development of children, and promoting safe, stable, and nurturing environments	Policy	

See also recommendations in Section 3b on improving access to home visiting and other supportive programs and Section 3c on increasing access to substance use and mental health disorder treatment to families in child welfare, supporting secure attachment between caregivers and young children at risk, and on increasing male caregivers' emotional support for their children.

e. Systems Collaboration and Data Sharing Challenges

Case review found that both care coordination prior to the fatal or near-fatal incident and investigation after the incident were sometimes hampered by lack of information sharing and systems to support collaboration. In one case, a family was being served by multiple health care providers, a home visitor, early intervention specialists, and in-home family preservation services from Baltimore City DSS. However, the family's needs were not being met, and no one agency or provider understood the range of concerns the other providers and agencies were attempting to address with the family. Concerns about confidentiality and lack of systems for identifying when agencies have clients in common prevented effective collaboration and recognition of the children's high risk of fatal abuse and neglect.

Concerns about confidentiality prevented effective collaboration between agencies

Health care coordination is especially important for at-risk children, as health care providers are in a unique position to recognize abuse and neglect, and as health care is a necessity for children who have been maltreated. Mechanisms do exist in Baltimore City to coordinate health care for children who have experienced abuse or neglect. When it is believed that a Baltimore City child may have been injured by a caregiver, police and child welfare staff are expected to present that child to JHH's Pediatric Emergency Department for a child maltreatment assessment. The child then has a thorough medical exam and social work interview. All of these cases of possible maltreatment are then reviewed by the Johns Hopkins Child Protection Team, a multidisciplinary group that includes a board-certified child abuse physician and a social worker. Review of cases not seen by JHH may also be sought by police, prosecutors, or CPS. The JHH Child Protection Team then ensures that follow-up occurs, including coordination with the child's primary care provider or referral for necessary specialty care. When abuse or other concerns are identified by the JHH Child Protection Team, the case is then brought to a multidisciplinary team of stakeholders called the Baltimore Citywide Child Protection Team (BCCPT) that includes CPS, law enforcement, and the State's Attorney's Office to facilitate information sharing and collaboration.

However, not all cases of abuse and neglect are seen at JHH or brought to the BCCPT, so many maltreated children do not receive subsequent health care coordination. Instituting protocols with hospital EDs and investigative agencies to ensure that all non-fatal cases are reviewed by the BCCPT would ensure better follow-up care and equip health care providers with information to provide quality services to their young patients. Ensuring all non-fatal cases are reviewed by the BCCPT would also lead to greater information sharing among investigative agencies and improved investigation with consistent input of specialized clinical expertise. In order to manage the increased caseload, the BCCPT would need additional staff resources.

The BCCPT does not review fatality cases; these cases are handled by the OCME, which, based on autopsy findings and investigation, declares the manner of death—homicide, to indicate intentional injury (abuse or severe neglect); accident, to indicate unintentional injury; or undetermined, to indicate intentionality of the injury is not able to be determined.

Holding a meeting of investigative agencies and clinicians immediately following an unexplained child fatality or a child fatality that is suspected to have resulted from abuse and neglect would provide greater opportunity for information sharing and improved investigations.

For example, in one initially unexplained infant fatality, CPS did not open an investigation and police did not pursue the case because there was no outward sign of trauma to the infant. After several weeks, the OCME ruled the manner of death to be undetermined after finding a hematoma to the infant's brain. The OCME was unable to determine independently whether the injury was intentional or due to trauma at birth. An explanation could have been pursued or uncovered had there been investigation. A year later, while under investigation for seriously injuring her new infant, the mother confessed to having killed her daughter. The new infant's injury may have been avoided if an investigation had been opened previously. Services could have intervened when the mother was pregnant, even if the investigation into the previous fatality had proved inconclusive.

Multidisciplinary investigative team meetings shortly after a fatality can improve communication

Several jurisdictions around the country have implemented multidisciplinary investigation team meetings within days following a child fatality to improve communications and information sharing, including Howard County in Maryland. New York City's Instant Response Team and Philadelphia's Act 33 Team, named for its enabling legislation, offer potential models for implementation of such a team in Baltimore City.

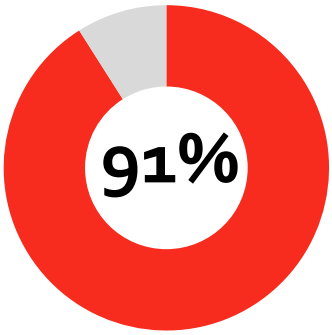
RECOMMENDATIONS

NO.	RECOMMENDATION	LEVEL	CECANF
30	Improve collaboration and coordination among social services agencies and health care providers		★
30.1	Develop and sign Memoranda of Understanding (MOUs) to enable child- and family-serving agencies, including home visiting programs, BITP, WIC, and child welfare agencies, to identify and share information about common clients and coordinate care and service delivery	Policy	★
30.2	Institute protocols for improving communication between home visiting providers and prenatal care and pediatric providers, potentially using CRISP to share information	Policy	
30.3	Continue to provide health care coordination for maltreated children via the Johns Hopkins Child Protection Team, building the capacity to bring more cases of suspected maltreatment to the BCCPT for review	Services	
30.4	Include a public health professional from BCHD or HCAM with access to health services information on the BCCPT to facilitate follow-up care coordination and service delivery	Services	
30.5	Enable access to CRISP and other key databases by BCCPT personnel, including non-physicians, to support care coordination	Policy	
31	Continue to review near-fatal cases of child abuse and neglect		★
31.1	Institute protocols across hospitals and investigative agencies to refer all cases of near-fatal child abuse and neglect to the Johns Hopkins Child Protection Team for review	Policy	★
31.2	Share BCCPT findings annually with Baltimore City CFR to inform ongoing monitoring of trends and development of recommendations for prevention and intervention	Policy	★
32	Facilitate information sharing among investigative and response agencies following a fatality		★
32.1	Create policy that requires a multidisciplinary investigative team for unexplained child fatalities and fatalities that are suspected to have been caused by child abuse or neglect to include the OMCE, law enforcement, prosecutors, CPS, clinical specialists, child abuse specialists, and other key personnel	Policy	★
32.3	Require multidisciplinary investigative teams to meet within a specified period of time after a fatality to review the case and share information, modeling such teams as New York City's Instant Response Team and Philadelphia's Act 33 Team	Policy	★

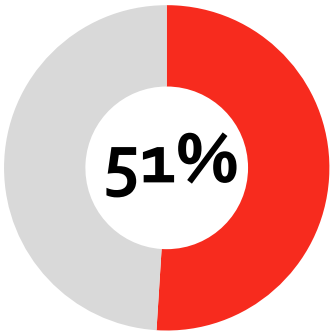
f. Social and Economic Adversity and Severe Stress

What was obvious in reviewing each of the 37 cases of fatal or near-fatal abuse and neglect is that Baltimore City families are facing tremendous challenges that result from longstanding social and economic policies and practices that unequally distribute power and advantage and leave many without the resources they need to raise children in a healthy and safe environment. The best available indication of the socioeconomic status of the families based on data gathered in the case review process is their health insurance status. In 32 of 37 cases reviewed (86%), families were found to be Medicaid recipients, meaning they had income levels near or below the federal poverty line ($18,871 for a family of three in 2015).[40] In an additional two cases (5%), families were confirmed to be uninsured and very low income.

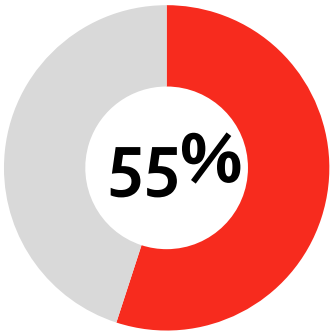
At such low incomes, housing, utilities, food, transportation, and other necessities are challenging to obtain. In multiple cases, families were found to be facing eviction at the time of the fatal or near-fatal incident and had experienced longstanding housing instability. One family was squatting in an abandoned home without a working bathroom and with mold covering the ceilings and walls. Another family had lived for months without electricity, with the father citing his frustration over unpaid bills as the reason he harmed his child. Another mother had been evicted and was staying in a motel with her boyfriend and toddler.



Families Who Were Medicaid Recipients or Uninsured



Mothers Who Had Their First Child as a Teenager



Caregivers with Less than High School Education

Fatalities and near fatalities most often occurred to families living in neighborhoods with high rates of violent crime, vacant housing, low educational attainment, teen birth, infant mortality, and other challenges associated with poverty, violence, and structural racism. In the 20 cases in which caregiver educational attainment was known, 11 (55%) children had at least one caregiver who did not graduate from high school. In 19 of 37 cases reviewed (51%), mothers were found to have delivered their first child as a teen, which can lead to family economic and social instability as young parents work to establish their households, often before they complete their education or find work that pays a living wage.

The adversity of poverty, violence, and racism is disproportionately faced by Baltimore's African American residents and other residents of color. This disparity is reflected in the cases reviewed, with children in 34 of 37 cases (92%) being of color (33 African American and one Hispanic) compared with 72% of all residents of Baltimore City.[41] CECANF found that African American children die as a result of abuse and neglect at two and a half times the rate of Caucasian children and reported hearing significant testimony regarding disproportionate responses from child welfare agencies, such as higher rates of foster care placement rather than reunification services among families of color, and regarding racism and implicit bias across systems serving families. Such disproportionality has led in many communities to understandable distrust and avoidance of the child welfare system and other systems that are supposed to support and protect children and families. A key CECANF recommendation worth heeding is to ensure that quality services are available to all children and families and that all families are treated equitably.

Recognizing Strengths and Building Resilience

Although the records and data gathered through the CFR process are much more likely to yield information about child and family risk factors and challenges than they do protective factors and strengths, child and family resilience in the face of adversity is extremely important to recognize and nurture. For example, as discussed in Section 3b, in 27 of the 29 cases (93%) we examined in which the child was under age 3, the child's mother had obtained prenatal care. That is evidence of her desire to care for herself and her child as well as her willingness to seek out services, potentially despite financial and other obstacles. That many caregivers also sought treatment for mental health and substance use disorders also indicates insight, a desire for support, and the self-efficacy to navigate often confusing treatment services. The presence of these strengths related to utilizing health care services also provides us with the clue that health care settings can make for good sites for prevention and intervention efforts.

Utilization of physical and behavioral health care was a strength across families

Becoming a trauma-informed city—a city that recognizes the adversity and trauma its residents have experienced and promotes the values of safety, trust, collaboration, and self-determination—can ensure that agency policies and services are welcoming, responsive, and sensitive to families' strengths. Trauma-informed care shifts the orientation of services that may react to families by asking, "What's wrong with you?" to ask instead, "What happened to you?" or "What have you experienced?" Under the leadership of Commissioner of Health Dr. Leana Wen, BCHD has been leading a movement to train city agencies, community-based organizations, and ultimately, all city residents on trauma-informed care. Several agencies have their own initiatives underway. Baltimore City DSS has been undergoing trauma-informed agency transformation and implemented Solutions-Based Casework, a model for operationalizing trauma-informed care in child welfare practice. BHB has trained home visitors, WIC, BITP, and other providers on providing trauma-informed care and offered trauma groups for postpartum mothers in its B'more Fit for Healthy Babies program. Maintaining the momentum is critical to building family resilience and creating change citywide that will lead to reduced child abuse and neglect.

Actively seeking to build family resilience, not only to reduce or mitigate the impact of family or caregiver risk factors, requires us to foster the protective factors that have been found to help people who face great adversity to thrive. The Strengthening Families Framework, a research-based approach to building five protective factors that enhance family well-being and prevent child abuse and neglect, has been adopted by many states and communities across the country. That includes Maryland, by the Maryland Family Network, Maryland's recipient of federal Community-Based Child Abuse Prevention funds. Efforts to reinforce the framework locally through BHB, with priority in neighborhoods that are disproportionately affected by adversity and child abuse and neglect, can foster resilience in greater numbers of families with young children.

We must build resilience, not only mitigate the impact of risk factors, to prevent fatalities

Supporting work to build the health of families and children in Baltimore City already underway through BHB, YHW, and their extensive partner networks has great potential to reduce factors underlying child abuse and neglect. BHB and YHW's Teen Pregnancy Prevention Initiative (TPPI) is working with Baltimore City Public Schools to implement evidence-based health and sex education in middle and high schools and increase access to effective contraception to help young people plan the start of their families. BHB has partnered with The People's Institute for Survival and Beyond to bring *Undoing Racism* workshops to BCHD and partners, spurring renewed efforts to dismantle racism in policies and in health and other services that impact Baltimore City's families. With the support of BHB and YHW's wide range of partners, we can increase advocacy for equitable state and local public policies that support families in providing a safe environment for their children.

RECOMMENDATIONS

NO.	RECOMMENDATION	LEVEL	CECANF
33	Transform Baltimore City into a trauma-informed city that is responsive to the needs of all families		
33.1	Continue to train leaders and staff of all city agencies and the early childhood service system on trauma-informed care and the science of adverse childhood experiences	Services	
33.2	Provide support for all city agencies and the early childhood service system to adopt the principles of trauma-informed care in policy and practice	Policy	
33.3	Operationalize trauma-informed care at the individual and family services level so that it is reflected in day-to-day work with families (e.g., continuing implementation of Solutions-Based Casework in child welfare, implementing the Fussy Baby Network FAN approach in home visiting programs)	Services	
34	Build family and community resilience in addition to addressing risk factors and maltreatment		
34.1	Use administrative child welfare and other data to understand which neighborhoods have disproportionate child welfare involvement and prevalence of risk factors	Policy	
34.2	Incrementally implement the evidence-based Strengthening Families model (implemented by Maryland Family Network) for building protective factors and promoting community norms for protecting children, with a focus on priority communities	Services	
35	Support the BHB TPPI Coalition strategies to reduce teen births		★
35.1	Continue efforts to implement comprehensive health and reproductive health education in Baltimore City Public Schools	Services	
35.2	Provide training and technical support to health care providers to ensure equitable access to all forms of effective contraception	Services	
35.3	Educate and empower youth to access effective forms of contraception through the U Choose/Know What U Want social marketing campaign	Community	
36	Advocate for public policies that support all families and advance equity through BHB and YHW		★
36.1	Continue to hold *Undoing Racism* workshops for a wide network of service providers and BHB partners	Services	
36.2	Network with BHB and YHW partners and grassroots organizations prior to and during each Maryland legislative session to identify policies to support or oppose and offer testimony	Policy	
36.3	Collaborate with SCCAN and the State CFR Team to advance policies that support the CDC's Essentials for Childhood Framework for safe, stable, and nurturing relationships	Policy	

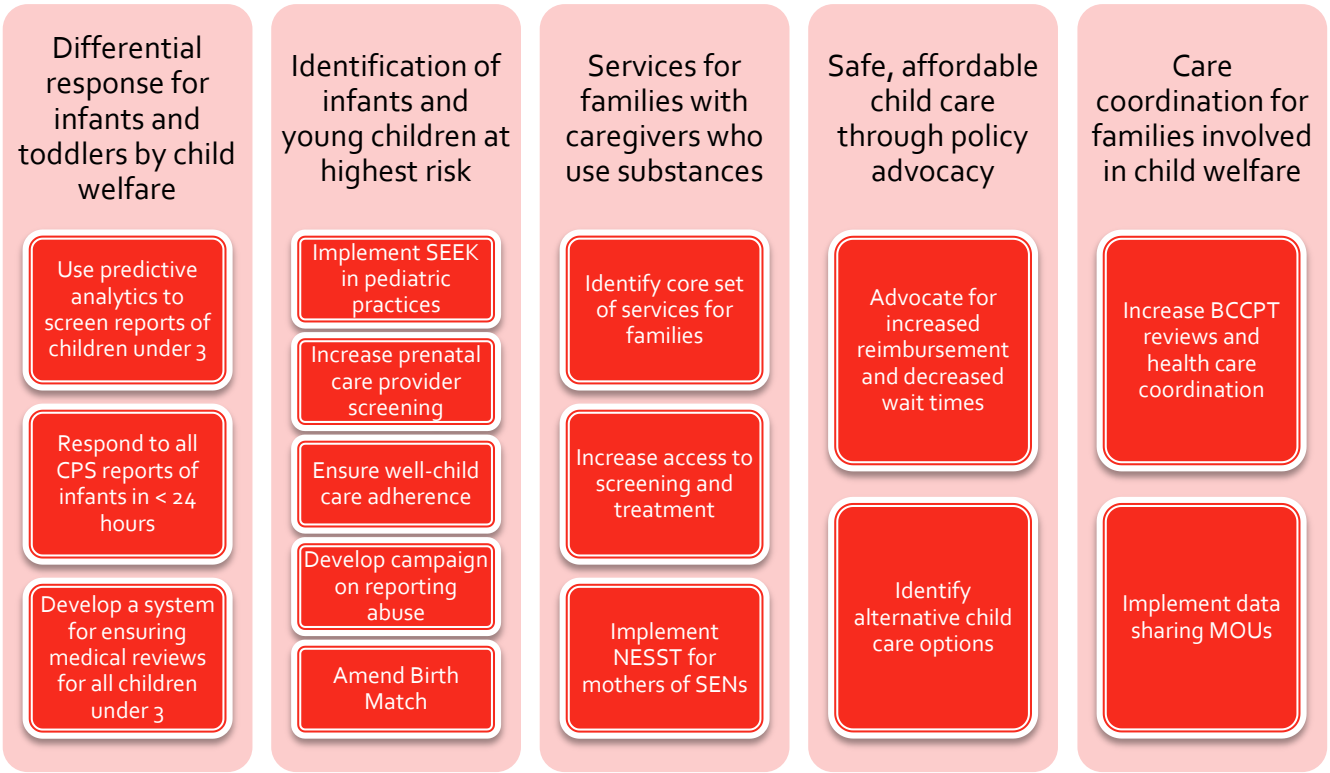
4. Taking Action Now to Save Children's Lives

Child abuse and neglect fatalities are preventable. We can eliminate them in Baltimore City if we take thoughtful action now. Case review findings by the Baltimore City CFR Subcommittee on Child Abuse and Neglect make it clear that preventing these fatalities is not simply a child welfare agency problem but a whole community problem. Solving it requires a public health approach—one that involves the whole community in identifying children and families most at risk, intervening early with services and supports to prevent abuse, and enacting policies that enable families to build resilience and provide safe homes for their children.

What will it take to eliminate child abuse and neglect fatalities in Baltimore City? The 36 recommendations offered in this report can serve as a starting point for action for BHB and partners across the city. Building on success of BHB's SLEEP SAFE initiative and myriad other efforts to prevent infant mortality, BHB and partners working as a coalition have the opportunity to pool their talents, expertise, and determination to save young children's lives.

Highest Impact Immediate-Term Recommendations

Implementing these 36 recommendations at once is not feasible, yet working on multiple fronts simultaneously is critical to success; there is no silver bullet in eliminating child abuse and neglect fatalities, only, as they say, silver buckshot. The subcommittee advises taking on first several recommendations that are most likely to yield high impact results in the immediate term: implementing a differential response for infants and toddlers by child welfare, increasing identification of infant and young children at highest risk for fatality, improving services for families with caregivers who use substances, and coordinating care for children involved in child welfare. From that ambitious starting point, BHB can prioritize next actions, taking into consideration leadership buy-in, fundraising needs, partner readiness, and community support.

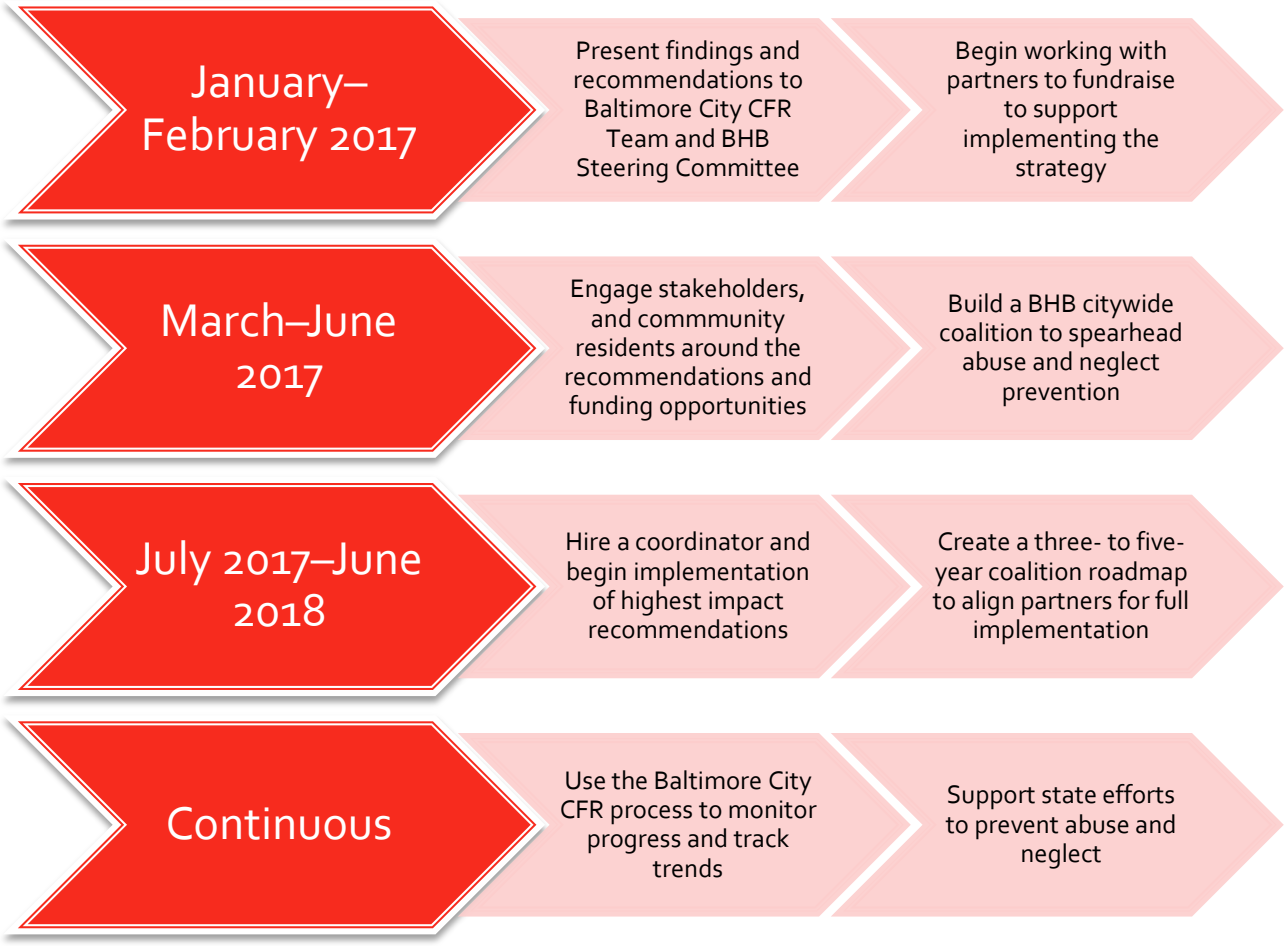


Action Plan for Next 18 Months

Work will ramp up immediately to prevent child abuse and neglect fatalities. In the next 18 months, the findings and recommendations contained in this report will be presented to the Commissioner of Health, Baltimore City CFR Team, and the BHB Steering Committee for feedback and guidance on the development of a preliminary implementation plan. Following these presentations, we will disseminate the report widely and hold multiple meetings to engage stakeholders and community residents and review the findings, recommendations, and preliminary implementation plans, soliciting revisions, creative ideas, and partnership opportunities. With stakeholders and residents, we will build a citywide BHB coalition around abuse and neglect prevention that will oversee the implementation plan.

Simultaneously, key partners to potentially include subcommittee members BCHD, Baltimore City DSS, Family League of Baltimore, HCAM, and University of Maryland will begin to identify possible funding to support an implementation coordinator and multiple streams of work, as it may require several months or more to secure funds. CECANF has recommended that Congress finance the development of multidisciplinary initiatives such as this one at the local and state levels. We will monitor developments on the funding front over time.

As the implementation coordinator and BHB undertake the high-impact, immediate-term recommendations above and create a three- to five-year roadmap for implementation of additional recommendations, we will continue to use the Baltimore City CFR process to monitor progress and track trends, as well as continue to contribute to the statewide efforts of SCCAN, MCANF, and the Three Branch Institute coalition to prevent fatalities. Together, we can take action to save young children's lives now.



Complete List of Recommendations

The following 36 recommendations were made by the Baltimore CFR Subcommittee on Child Abuse and Neglect to prevent severe and fatal child abuse and neglect in Baltimore City. Recommendations that are closely aligned with or that represent a local adaptation of the CECANF recommendations released in March 2016 are indicated with a ★.

NO.	RECOMMENDATION	LEVEL	CECANF
1	Implement a differential response by the child welfare system for infants and toddlers		★
1.1	Implement predictive analytics model for screening CPS reports based on risk for severe and fatal maltreatment for all infants and children under 3 years old	Policy	
1.2	Train CPS screeners on identifying specific risk factors for fatality to aid in decision making	Services	
1.3	Respond to all screened in CPS reports of infants under 1 year old within 24 hours	Policy	★
1.4	Explore the development of a public health response for all infants and toddlers who have been the subject of a CPS report that has been screened out	Policy	
1.5	Develop a system for ensuring all CPS reports for infants and children under 3 years old are reviewed by a health care provider with expertise in identifying child abuse and neglect	Policy	★
1.6	Increase the frequency of visits for children under 3 years old served by the child welfare system	Policy	★
1.7	Provide specialized training for child welfare workers and court personnel on the needs of infants and toddlers and availability of local service systems for prevention and intervention	Services	
2	Improve identification of risk for abuse and neglect and chronic abuse and neglect by the health care system		★
2.1	Obtain a waiver to provide reimbursement to primary care providers for caregiver risk-factor screening through Maryland Medicaid's Healthy Kids Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program	Policy	★
2.2	Implement the evidence-based SEEK model in pediatric practices citywide to increase screening caregivers for risk factors for child abuse and neglect, providing education, and referring to community services	Services	
2.3	Create a central repository of local prevention resources and services for pediatric practices to reference for referrals when caregivers screen positive for risk factors for abuse and neglect	Services	
2.4	Train ED physicians and pediatricians to use standardized tools for evaluation and documentation of child abuse and neglect	Services	
2.5	Create a consultation service that enables ED physicians and pediatricians to access telephone consultation and medical record review by child abuse experts in Maryland's Child Abuse Medical Professionals (CHAMP) network and/or the Baltimore Citywide Child Protection Team (BCCPT)	Services	
2.6	Create an automated system using CRISP, the regional health information exchange, to flag potential cases of child abuse and neglect in which medical care has been sought for review by ED physicians and pediatricians	Services	★
2.7	Provide pediatricians with real-time access via CRISP to Maryland Prenatal Risk Assessment (MPRA) and Postpartum Infant and Maternal Referral (PIMR) forms from the child's mother's obstetric care records	Services	
2.8	Enforce regulations requiring MCOs to identify, outreach, and link back into care children under age 2 who are not receiving well-child care according to Maryland Medicaid's Healthy Kids EPSDT schedule	Policy	
3	Increase accountability for reporting to CPS by professionals, family members, and bystanders		★
3.1	Train child welfare workers, home visitors, Medicaid care coordination associates, early intervention services providers, WIC staff, and child care providers on recognizing risk factors for severe and fatal abuse and screening caregivers for risk factors	Services	
3.2	Improve Maryland training programs for mandatory reporters of abuse and neglect by including the specific signs and risk factors for abuse and neglect of infants and toddlers	Services	
3.3	Require training on reporting for mandatory reporters who need to maintain licenses in their fields	Policy	★
3.4	Launch a public social marketing campaign based on formative research to increase reporting of child abuse and neglect by community residents	Community	

NO.	RECOMMENDATION	LEVEL	CECANF
4	Amend Maryland's Save Haven law to protect all infants from abuse and fatality		★
4.1	Extend the maximum age at which an infant can be voluntarily relinquished from 10 days to 1 year	Policy	★
4.2	Mandate community promotion of the law, including signage at all safe haven sites	Community	★
5	Amend Maryland's Birth Match law to improve identification of newborns at high risk of fatality		★
5.1	Require courts to terminate the parental rights of parents culpable in the death of their children to ensure that these parents are identified by Birth Match if they have subsequent children	Policy	
5.2	Match parents who have not contested the child welfare system's decision to seek termination of their parental rights (excluding parents who are the initiators of voluntary adoption processes for their children)	Policy	
5.3	Match parents who have a previous criminal conviction of abuse and neglect, including child homicide	Policy	
5.4	Extend the matching timeframe from the previous 5 years to the previous 20 years	Policy	
6	Utilize multiple sources of local data to monitor risks over time to inform policy and services initiatives		★
6.1	Link data from Baltimore City vital records, MPRAs, and other records to administrative child welfare data to identify early risk factors that predict child abuse and neglect and inform targeting of services	Policy	
6.2	Maintain and publicly disseminate a detailed profile of risk and protective factors in child abuse and neglect fatality cases utilizing data gathered through Baltimore City CFR	Policy	
7	Increase prenatal care providers' timely completion and submission of MPRAs per state policy		
7.1	Develop a system to be used by Maryland's Medicaid program to generate a regularly updated list of all prenatal care providers serving Medicaid recipients and their MPRA completion rates for purposes of conducting ongoing provider education on MPRA procedures	Services	
7.2	Create scorecards that provide feedback to individual prenatal care providers on their MPRA completion rates	Services	
7.3	Complete the pilot project currently underway to embed the MPRA in electronic health records and scale up implementation to prenatal care providers citywide	Policy	
7.4	Provide technical assistance to prenatal care providers in designing optimal clinic flow to support MPRA completion	Services	
7.5	Engage community-based organizations and community residents in understanding a pregnant Medicaid recipient's right to an MPRA and linkage to services to generate demand for MPRAs	Community	
8	Increase birthing hospitals' timely completion and submission of PIMRs per state policy		
8.1	Streamline the PIMR form and completion process in partnership with the Maryland Department of Health and Mental Hygiene and train birthing hospitals on revised procedures	Policy	
8.2	Regularly convene social workers in labor and delivery units and NICUs in all Baltimore-area birthing hospitals to troubleshoot PIMR completion processes and review submission rates	Services	
9	Increase use of creative engagement strategies to reach hard-to-reach pregnant women and families		
9.1	Identify sustainable sources of funding for HCAM's pregnancy engagement specialists and for increased engagement staff	Policy	
9.2	Provide city home visiting programs with access to pregnancy engagement specialists to assist in outreach for enrollment after a referral has been received	Services	
9.3	Develop and implement models of peer-based outreach and engagement, particularly when working with pregnant women and families that are members of stigmatized groups (e.g., substance users)	Services	
9.4	Rebrand home visiting services using top-down and grassroots strategies to dispel myths and misperceptions and generate demand for services	Community	
9.5	Continue the existing collaboration with the Johns Hopkins University School of Nursing to understand the strengths and needs of hard-to-reach pregnant women to inform creative engagement strategies	Services	
10	Eliminate administrative barriers to enrolling pregnant women and families in home visiting services		
10.1	Eliminate perceived barriers to referring and enrolling high-risk mothers and infants following delivery (as opposed to during pregnancy) by city home visiting programs	Policy	
10.2	Streamline processes to expedite the enrollment of teen mothers in foster care in home visiting services	Policy	★
10.3	Develop and implement procedures to enable the enrollment in home visiting of infants placed into kin care by the child welfare system	Policy	

NO.	RECOMMENDATION	LEVEL	CECANF
11	Implement a common systematic approach to strengthening engagement across early childhood services		
11.1	Train local trainers on the Fussy Baby Network FAN approach to family engagement, a national model for operationalizing trauma-informed care and improving family engagement, to build a sustainable model for implementation citywide	Services	
11.2	Train and implement the FAN approach with HCAM CCP staff and home visiting providers, evaluating changes in rates of initial engagement and enrollment and of program retention	Services	
11.3	Scale up implementation of the FAN approach over time in WIC, BITP, child care programs, the child welfare system, and pediatric practices	Services	
12	Continue to build a prenatal care-to-kindergarten pipeline to avoid missed opportunities for intervention		
12.1	Identify sustainable, non-Medicaid sources of funding to ensure the HCAM CCP can provide pregnant women and infants with assessment and linkage to non-Medicaid community services and supports	Policy	
12.2	Continue to streamline referral processes and offer priority enrollment from home visiting to Head Start and from Head Start to Pre-K, where families will receive continued risk screening and supports	Services	
13	Improve accurate and equitable identification of SENs to inform decisions about policy and services		★
13.1	Implement policies for universal toxicology testing and CPS reporting of SENs at birthing hospitals to eliminate biases and lapses in testing and reporting	Policy	
13.2	Increase birthing hospitals' submission of PIMRs for all SENs, consistent with existing state policy, to ensure they are linked to community services including home visiting	Services	
13.3	Systematically collect detailed data at Maryland DHR on hospital reports of SENs and regularly share data with local health departments to improve the ability to plan and provide services	Policy	
14	Improve access to and quality of services to mothers, SENs, and families affected by substance use		
14.1	Bring together stakeholders through the BHB PSEP Coalition to ensure that parents of children under 5, including those in kin care as a result of substance use, have access to a full range of services and supports to build resilience, improve parenting skills, and prevent maltreatment	Services	
14.2	Advocate for legislation to support collaborative planning during pregnancy between health care providers and CPS to facilitate coordinated plans of safe care for mother and baby, avoid emergency removals of SENs, and improve services to mothers and families, adapting the Children and Recovering Mothers (CHARM) Collaborative model for Baltimore City	Policy	
14.3	Provide advanced training and ongoing support to home visiting providers and other early childhood service providers on addressing the needs of caregivers who use substances and SENs	Services	
14.4	Expand the capacity of the city's HFA home visiting programs to meet the greater demand for services posed by increased referrals for families of SENs, managing the impact of services for SENs on the centralized intake system for pregnant women and infants and the coordinated home visiting system	Services	
14.5	Develop and implement an alternative to traditional home visiting programs for mothers with opioid and cocaine dependence that utilizes clinical therapy and peer-based mentoring, adapting the NESST model for Baltimore City	Services	
14.6	Involve birth parents (those in recovery who have had children removed from their care due to substance use) in designing effective child welfare programs and prevention strategies for families affected by substance use	Community	
15	Support the work of the BHB PSEP Coalition to prevent and address substance-exposed pregnancies		
15.1	Increase access to family planning services for pregnant women and women of reproductive age who are using substances	Services	
15.2	Increase the use of the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) model in settings that serve girls and women of reproductive age	Services	
15.3	Increase access to substance use disorder treatment for girls and women who are pregnant or of reproductive age who are using substances, diversifying the range of treatment options available	Services	
15.4	Develop and implement a strategy for using peer recovery workers to conduct street outreach and encourage pregnant women using substances to seek prenatal care and treatment	Community	
15.5	Provide training to prenatal care providers to improve knowledge, attitudes, and beliefs related to pregnancy and substance use; reduce stigma; and improve quality of care	Services	
15.6	Provide training and technical assistance to prenatal care providers to increase adherence to American College of Obstetrics and Gynecology (ACOG) practice guidelines for screening pregnant and postpartum women for substance use	Services	

NO.	RECOMMENDATION	LEVEL	CECANF
15.7	Develop and implement a policy advocacy strategy to prevent the development of substance use disorders in girls and women (e.g., advocating for changes to the built environment such as decreased liquor store density)	Policy	
16	Support forthcoming recommendations of Baltimore City Fetal-Infant Mortality Review (FIMR) and the Maryland Maternal Mental Health Task Force to address mental health in pregnancy and postpartum		
16.1	Provide training and technical assistance to prenatal care providers to increase adherence to ACOG practice guidelines for screening pregnant and postpartum women for mental health disorders	Services	
16.2	Provide training for prenatal care providers and psychiatric providers on the use of psychiatric medications during pregnancy and risks of discontinuing medications	Services	
16.3	Provide training for prenatal care providers and mental health providers to address maternal mental health during pregnancy and improve coordination of care	Services	
16.4	Enable prenatal care providers to access telephone consultation from psychiatric providers through an expansion of the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) model	Services	
16.5	Develop and implement a strategy for utilizing peer navigators to support women in accessing treatment for mental health disorders	Community	
16.6	Launch a public social marketing campaign to increase community awareness of maternal mental health concerns and generate demand for treatment	Community	
17	Improve access to substance use and mental health disorder treatment for all caregivers who need it		★
17.1	Make substance use and mental health screening universal for all caregivers involved in the child welfare system using a standardized tool and an evidence-based intervention model such as SBIRT	Services	
17.2	Train child welfare workers and health care providers, especially prenatal and pediatric providers, to use Baltimore City's 24/7 Crisis, Information & Referral Line to link caregivers to treatment	Services	
17.3	Launch a public social marketing campaign to heavily promote the Crisis, Information & Referral Line to raise awareness of treatment options and generate demand for treatment	Community	
18	Support healthy, secure attachment between caregivers and young children at risk		
18.1	Expand use of the Circle of Security Parenting model citywide to promote secure attachment using consistent language and intervention strategies across the early childhood system	Services	
18.2	Expand infant mental health consultation services in home visiting, WIC, BITP, child care settings, and pediatric practices	Services	★
18.3	Expand the work of BHB to train peer breastfeeding counselors and promote breastfeeding initiation and duration to improve attachment	Community	
18.4	Develop a policy at each Baltimore-area NICU for supporting attachment, particularly for infants with neonatal abstinence syndrome	Policy	
19	Increase fathers and mothers' male partners' emotional support of their children and families		
19.1	Collaborate with partners to further infuse fatherhood and male responsibility initiatives into settings with boys and men in Baltimore City	Services	
19.2	Make deliberate and special efforts to include male caregivers in attachment and parenting skills programs (e.g., Circle of Security Parenting, home visiting sessions)	Services	
20	Improve early identification of and intervention for IPV in families with young children		
20.1	Provide training and technical assistance to prenatal care providers to increase adherence to ACOG practice guidelines for screening pregnant and postpartum women for IPV	Services	
20.2	Train prenatal care providers to use CRISP to identify injuries for which their patients have sought care that may have resulted from IPV and provide linkage to services	Services	
20.3	Increase rates of IPV screening and intervention in home visiting programs, adopting an evidence-based model of brief intervention such as the Domestic Violence Enhanced Home Visiting model	Services	
20.4	Screen women for IPV in WIC program sites	Services	
21	Provide supports to prevent child abuse and neglect when IPV has been identified		★
21.1	Collaborate with IPV service partners in Baltimore City to assess families for potential child abuse and neglect and link them to supportive services	Services	
21.2	Collaborate with legal clinics and courts hearing peace and protective order cases to link families with young children to supportive services	Services	

NO.	RECOMMENDATION	LEVEL	CECANF
21.3	Provide training to ED providers on counseling and safety planning for families with young children when IPV has been identified in the ED	Services	
22	Improve access to and effectiveness of the Maryland Child Care Subsidy (CCS) Program		
22.1	Eliminate waiting lists for CCS vouchers to enable families to access safe child care, including while they are obtaining employment	Policy	
22.2	Streamline the lengthy process for obtaining CCS vouchers for families not using TANF/TCA, enabling the Baltimore City Child Care Resource and Referral Center to take applications on site rather than requiring applications be faxed	Policy	
22.3	Increase reimbursement rates for CCS vouchers to ensure the vouchers cover a greater share of child care costs and enable meaningful access to child care for low- and very low-income families	Policy	
23	Expand child care options, particularly in communities that are child care deserts		
23.1	Develop new and expand existing options for crisis, respite, and drop-in child care in Baltimore City	Services	
23.2	Collaborate with grassroots and other community-based organizations to implement child care cooperatives in which caregivers become trained child care providers and barter services	Services	
23.3	Incentivize workplaces to provide assistance with funding child care or offering on-site child care	Policy	
24	Educate mothers and families about the need to choose safe caregivers for infants and young children		
24.1	Launch a public social marketing campaign based on formative research to raise awareness of the need to vet informal child care providers and access alternative options	Community	
24.2	Offer ongoing support to legal guardians of children removed from their biological parents' care in navigating child care and family dynamics when they remain in contact with the child's parents	Services	
25	Fully landscape and support existing effective parenting support resources in Baltimore City		
25.1	Monitor implementation of NFP home visiting with first-time mothers under age 24, expanding if demand exceeds present capacity	Services	
25.2	Monitor the Family Tree pilot of the evidence-based *Maryland Family Connects* short-term home visiting program, collaborating to expand the model citywide if effective	Services	
25.3	Landscape parent support programs (e.g., Chicago Parent Program, Parent University, Incredible Years) available in Baltimore City and facilitate referrals by a wide range of providers	Services	
25.4	Expand social marketing for the Family Tree 24/7 Parenting HelpLine to increase utilization, with special attention to reaching male caregivers	Community	
26	Implement targeted education programs to prevent inappropriate responses to child behavior		
26.1	Incorporate education prenatally and postpartum on preventing abusive head trauma, responding to infant and child crying, and managing other child behaviors in home visiting, at postpartum discharge, and at WIC program sites	Services	
26.2	Educate parents with infants in the NICU about increased risk of abuse and strategies for addressing behavioral concerns that may accompany the infant's medical conditions	Services	
26.3	Educate all clients of behavioral health treatment providers about the importance of keeping methadone and other medications away from infants and children and not using them to quell crying	Services	
27	Provide intensive treatment and supports for children and caregivers involved in the child welfare system		★
27.1	Increase access to and utilization of the substantial individual and family trauma treatment services in Baltimore City (e.g., trauma-focused cognitive behavioral therapy, Strengthening Family Coping Resources, Parent-Child Interaction Therapy)	Services	
27.2	Provide intensive supports across a range of concerns (e.g., mental health, financial, parenting) to youth in foster care, especially youth who are pregnant and parenting	Services	★
27.3	Include history in foster care or as a victim of abuse or neglect in the criteria for prioritizing pregnant women and mothers for city home visiting services	Policy	
27.4	Continue to train and support child welfare workers, home visitors, and early childhood service providers in adopting trauma-informed care	Services	
28	Ensure adequate supports are provided to families with active child welfare cases		★
28.1	Continue and expand offerings of behavioral parent training programs to caregivers	Services	★

NO.	RECOMMENDATION	LEVEL	CECANF
28.2	Consider the adoption of predictive analytic tools or augmented administrative review processes to identify child welfare cases that may lack the necessary service components or have inadequate staff support to address the risks of severe or fatal maltreatment	Policy	★
29	Intervene in childhood to support these future caregivers in developing emotional self-regulation		
29.1	Support and expand early childhood initiatives that teach foundational social-emotional skills and promote emotional self-regulation, such as Maryland's Social and Emotional Foundations of Early Learning (SEFEL) project	Services	
29.2	Support and expand school-based initiatives to increase social-emotional competence and promote emotional self-regulation, such as Positive Behavioral Interventions and Support, mindfulness training, and social skills teaching	Services	
29.3	Support work by SCCAN to implement the CDC's Essentials for Childhood framework for preventing adverse childhood experiences, improving the social-emotional development of children, and promoting safe, stable, and nurturing environments	Policy	
30	Improve collaboration and coordination among social services agencies and health care providers		★
30.1	Develop and sign Memoranda of Understanding (MOUs) to enable child- and family-serving agencies, including home visiting programs, BITP, WIC, and child welfare agencies, to identify and share information about common clients and coordinate care and service delivery	Policy	★
30.2	Institute protocols for improving communication between home visiting providers and prenatal care and pediatric providers, potentially using CRISP to share information	Policy	
30.3	Continue to provide health care coordination for maltreated children via the Johns Hopkins Child Protection Team, building the capacity to bring more cases of suspected maltreatment to the BCCPT for review	Services	
30.4	Include a public health professional from BCHD or HCAM with access to health services information on the BCCPT to facilitate follow-up care coordination and service delivery	Services	
30.5	Enable access to CRISP and other key databases by BCCPT personnel, including non-physicians, to support care coordination	Policy	
31	Continue to review near-fatal cases of child abuse and neglect		★
31.1	Institute protocols across hospitals and investigative agencies to refer all cases of near-fatal child abuse and neglect to the Johns Hopkins Child Protection Team for review	Policy	★
31.2	Share BCCPT findings annually with Baltimore City CFR to inform ongoing monitoring of trends and development of recommendations for prevention and intervention	Policy	★
32	Facilitate information sharing among investigative and response agencies following a fatality		★
32.1	Create policy that requires a multidisciplinary investigative team for unexplained child fatalities and fatalities that are suspected to have been caused by child abuse or neglect to include the OMCE, law enforcement, prosecutors, CPS, clinical specialists, child abuse specialists, and other key personnel	Policy	★
32.3	Require multidisciplinary investigative teams to meet within a specified period of time after a fatality to review the case and share information, modeling such teams as New York City's Instant Response Team and Philadelphia's Act 33 Team	Policy	★
33	Transform Baltimore City into a trauma-informed city that is responsive to the needs of all families		
33.1	Continue to train leaders and staff of all city agencies and the early childhood service system on trauma-informed care and the science of adverse childhood experiences	Services	
33.2	Provide support for all city agencies and the early childhood service system to adopt the principles of trauma-informed care in policy and practice	Policy	
33.3	Operationalize trauma-informed care at the individual and family services level so that it is reflected in day-to-day work with families (e.g., continuing implementation of Solutions-Based Casework in child welfare, implementing the Fussy Baby Network FAN approach in home visiting programs)	Services	
34	Build family and community resilience in addition to addressing risk factors and maltreatment		
34.1	Use administrative child welfare and other data to understand which neighborhoods have disproportionate child welfare involvement and prevalence of risk factors	Policy	
34.2	Incrementally implement the evidence-based Strengthening Families model (implemented by Maryland Family Network) for building protective factors and promoting community norms for protecting children, with a focus on priority communities	Services	

NO.	RECOMMENDATION	LEVEL	CECANF
35	Support the BHB TPPI Coalition strategies to reduce teen births		★
35.1	Continue efforts to implement comprehensive health and reproductive health education in Baltimore City Public Schools	Services	
35.2	Provide training and technical support to health care providers to ensure equitable access to all forms of effective contraception	Services	
35.3	Educate and empower youth to access effective forms of contraception through the U Choose/Know What U Want social marketing campaign	Community	
36	Advocate for public policies that support all families and advance equity through BHB and YHW		★
36.1	Continue to hold *Undoing Racism* workshops for a wide network of service providers and BHB partners	Services	
36.2	Network with BHB and YHW partners and grassroots organizations prior to and during each Maryland legislative session to identify policies to support or oppose and offer testimony	Policy	
36.3	Collaborate with SCCAN and the State CFR Team to advance policies that support the CDC's Essentials for Childhood Framework for safe, stable, and nurturing relationships	Policy	

CFR Subcommittee on Child Abuse and Neglect List of Members

The following BCHD staff and members of the Baltimore City CFR Team undertook this project to review cases of fatal and near-fatal child abuse and neglect, investigate potential solutions, and make the recommendations contained in this report to prevent severe and fatal child maltreatment in Baltimore City.

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The subcommittee finally wishes to acknowledge the amazing strength and resilience of families in Baltimore City, who are working every day to provide the best lives to their young children in the face of numerous obstacles and challenges. It is our hope that the work of Baltimore CFR and BHB to prevent child abuse and neglect fatalities will result in better systems, better services, and a better city in which to raise our youngest residents.

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