Child Fatality Task Force
February 3, 2014 Minutes (Approved 4/7/14)

Members: Sen. Austin Allran, Sen. Chad Barefoot, Sen. Stan Bingham, Cindy Bizzell, Dr. Robin Cummings, Dr. Elaine Cabinum-Foeller, Sen. Don Davis, Rep. Jim Fulghum, Martha Sue Hall, Kevin Kelley, Dr. Martin McCaffrey, Karen McLeod, Dr. Peter Morris, Stephanie Nantz, *Dr. Deborah Radisch,* Susan Robinson, Dr. Kevin Ryan, *Rep. Paul Stam*, Vanessa Totten, Greg Tart, Dr. Sarah Verbiest, Buck Wilson, Alan Dellapenna, Michelle Hughes, Belinda Pettiford

Guests: Thomas Caves, Dr. Max Crowley, *Cara Derounian,* Annaliese Dolph, *Anna Dulaney*, Brenda Edwards, Janice Freedman, *Dr. Hendree Jones*, Judith Johnson Jones, Trishana Jones, Maria Kinnaird, Rachel Larson, *Dr. Miriam Labbok*, Dr. Steve Marshall, Dr. Gerri Mattson, *Jessica Middlebrooks*, Amy Mullenix, Peg O'Connell, Jan Parker, Scott Proescholdbell, Jeff Quinn, Kelly Ransdell, *Sharon Rhyne*, Dr. Joel Rosch, Jere Royall, Kay Sanford, Meghan Shanahan, Catherine Sullivan, *Jennifer Woody*, + at least 2 additional

Italics Indicates by Phone

All presentations are available on the CFTF website.

Dr. Peter Morris welcomed members and guests who then introduced themselves.

Dr. Elaine Cabinum-Foeller moved and Stephanie Nantz seconded approval of the minutes which were unanimously affirmed.

Karen McLeod explained the CFTF committee structure. The CFTF vets and works issues through our three committees: Unintentional Death, Intentional Death Prevention and Perinatal Health. We rely on both our members and our volunteer committee members for their expertise and participation. Since many new members have recently joined the CFTF, for today's meeting we invited back speakers from previous committee meetings to give members and participants a taste of what each committee is like. CFTF members are encouraged to participate with at least one committee.

Unintentional Death

Alan Dellapenna, co-chair of the Unintentional Death Committee recapped highlights from the past meeting, focused on road safety.

- **Diversion program** to improve child car safety seat use promoted by Safe Kids. (More below.)
- **Passing stopped school buses** – the science is still emerging and improvements have been made, but we don't have concrete recommendations on specific evidence-based steps. Some expressed that broadening prosecution options (allowing some lower level charges and punishments) might encourage more charges and prosecutions to be brought forward. Many thanks to Derek Graham from DPI for his presentation.
- **Distracted driving** – evidence is quite clear that it is dangerous. However, there do not yet seem to be evidence-based programs proven effective at getting people off their phones while they drive. In general, high visibility enforcement -- that increases perception of being caught and facing consequences -- is effective for behavior change in traffic situations. For distracted driving specifically, emerging technology and peer-to-peer programs are promising, but not proven. In contrast, fear-based campaigns do not work on a population level. Many thanks to Arthur Goodwin from the UNC Highway Safety Research Center for his presentation.

- **Supervised driving app** – We learned about a new app from the Highway Safety Research Center that helps parents keep track of their teens' driving by monitoring driving hours, routes and hard stops. It just recently rolled out; preliminary feedback is positive. Many thanks to Natalie O'Brien from the UNC Highway Safety Research Center for her presentation. Link to app: http://www.timetodriveapp.com/
- **Scooters** – Sen. Bingham seeks CFTF endorsement of legislation he plans to introduce to require drivers of scooters to wear reflective vests. We learned that children do die on scooters, but it's thankfully rare. Almost half of scooter deaths occur at in later afternoon (2PM-6PM).

Martha Sue Hall, co-chair of UDC, introduced Kelly Ransdell, Director of NC Safe Kids. Safe Kids both helps inform UDC's policy discussion, plus puts feet to the policy with their work on many overlapping issues.

Kelly Ransdell informed the group about the many overlapping ways in which Safe Kids informs and helps transform into practice the policies advanced by the CFTF, as well as other efforts to reduce childhood injury and death. Efforts include work on:

- Child passenger safety
- Drowning
- Hot Cars
- Smoke Alarms
- CO Detectors
- Gun Safety
- Drowning
- Poison control, including Operation Medicine Drop.

By way of just two examples:

Promoting use of child car safety seats: While the CFTF worked to pass laws relating to safety seats for children, Safe Kids has checking stations (Buckle Up) across the state to help parents make sure the seats are correctly installed. Most recently, Safe Kids has begun working with counties on a voluntary basis on a Diversion Program. Parents charged with failure to use a properly installed car seat -- rather than get charges dismissed by merely bringing any car seat to court -- must demonstrate that they have a seat appropriate to the child; it is correctly installed; and a one-on-one appointment with a certified technician to learn the importance of passenger safety for their child.

Prescription Drug Diversion: Operation Medicine Drop works with law enforcement and others to provide "drop off" sites for unneeded medications which are then counted and safely disposed. The forms and procedures developed by NC Safe Kids have become a national model. Collections have increased more than 16 fold in the past 3 years (from a little over 1 million doses in 2010 to more than 18 million doses in 2013).

<u>Intentional Death Prevention</u>

Michelle Hughes, co-chair of IDPC, provided an overview of the committee which looks at three main types of child death: youth suicide, juvenile or community violence, and violence by parents against children. The committee examines overlapping ways in which preventing violence against young children now prevents suicide and violence by teens later and preventing violence by and against teens now can strengthen family functioning later – or as committee members like to say, prevention is

prevention is prevention. When looking at statewide implementation of prevention programs, it is critical to use evidence-based programs implemented with fidelity. Especially when we know what works, it is a much more effective use of resources to target time, energy and money to proven programs. In contrast, it can waste money and other resources when they go towards programs that are ineffective or unproven. It is also critical that communities are ready and capable to implement.

The next meeting Monday, Feb 24th at 10AM and will likely last until 12:30 given complexity of the topic: disrupted adoptions. Sometimes when parents adopt very high needs children, they may need extra support to keep the children safely in their homes. We'll be bringing in experts who deal with these tough cases on a daily basis, look at system issues and discuss strategies for improvements to make recommendations to the full CFTF at the April meeting.

Dr. Cabinum-Foeller, IDPC co-chair, summarized past meetings of the IDPC. At our first meeting we looked at home visiting, evidence-based and evidence-informed family strengthening strategies designed around the birth of a child, such as Nurse Family Partnership, Healthy Families and Durham Connects.

The highlights from the second meeting include the following:

LONGSCAN: Dr. Adam Zolotor and Liz Knight from UNC-CH presented on a multi-decade study of abuse and neglect called LONGSCAN. One key finding was that, in a cohort of children at-risk, the High Priority Infant Program screening tool predicts with 93% accuracy that an at-risk child by the time he/she reaches his/her 18th birthday is characterized by experiencing one or more of the following three outcomes: 1) Child was reported for child abuse or neglect; 2) Child self-reported to an interviewer that they had been abused or neglected; or 3) Child witnessed interpersonal violence in the home or neighborhood. Findings also stressed the need for on-going supports even after permanency. Indeed, social support and medical treatment, including mental health services, can ameliorate the effect and abuse and neglect and may keep it from re-occurring or even happening in the first place.

Domestic Violence: CFTF member Sgt. John Guard from Pitt Co talked about two evidence-based approaches being explored in Pitt County to deal with the most dangerous domestic violence situation where homicide is deemed highly likely. Pitt Co. was one 12 areas to win a national demonstration grant.

Impact of Public Policy Decisions in Promoting or Preventing Violence –Drs. Joel Rosch and Max Crowley presented on the importance of using evidence-based programs implemented with fidelity to assure the best results for NC children.

Dr. Joel Rosch and Dr. Max Crowley from the Center for Child and Family Policy talked about effective prevention programs. Dr. Rosch said that 30-40 years ago there was a serious lack of evidence-based programs proven to work. An ounce of prevention is only worth a pound of punishment if the prevention program is actually effective at prevention. Effective prevention can have multiple benefits, often for the child, family, community and state budget. In the intervening years, research has shown us programs that can be effective when implemented with fidelity in ready communities.

Dr. Crowley noted that cost and effectiveness vary depending on where in the life cycle policies intervene. In general, early intervention tends to produce strong results at lower cost. The Washington State Institute for Public Policy (WSIPP) has created a model for assessing whether or not a program is

likely to save their State tax payer dollars over time. Their "Blueprint" is very rigorous and all studies must meet certain high standards (and no harmful treatment effects) to be included in the analysis. Not all interventions have the high quality evaluations required to be part of the Blueprint. (In other words, not all programs – even evidence-informed programs - have been rigorously evaluated over time for effectiveness and cost benefit.)

Dr. Crowley walked members through the WSIPP analysis structure. Programs could be effective, but not produce taxpayer savings in the end. Programs could be effective and produce taxpayer savings in the end, but other programs might save more taxpayer dollars over time. The most cost effective programs sometimes cost more upfront. Just because a program is proven and cost effective does not mean it works with all populations. It is important to use the right program for the population, not just the most cost effective program. Examples of programs that were effective and produced long-term savings included Nurse Family Partnership and Parent-Child Interaction Therapy. Some programs actually end up costing the State more, as the State incurs program costs and results are counter to the intention. The example was Scared Straight – a juvenile justice intervention which has been shown to increase crime.

Sen. Allran expressed interest in using the LONGSCAN screening tool to target services. (Screening criteria are appended below per request.) Dr. Rosch reiterated the importance of using the right intervention at the right time. Dr. Crowley noted the tension between "giving a little to a lot or giving a lot to a little." Dr. Cabinum-Foeller added that some programs are more prevention focused; different programs work at different times and in different ways; that is why a continuum of supports is needed. Dr. Rosch urged policy-makers to consider picking a few programs and doing them well rather than creating many programs with weak infrastructure; local partners should be encouraged to use a few evidence-based programs across the continuum rather than a myriad of similar programs.

Sen. Davis had follow-up questions about Scared Straight. Dr. Crowley elaborated that a randomized controlled trial verified that Scared Straight actually increased deviant behavior.

Sens. Barefoot suggested preparing a list of early prevention programs currently funded by the State and looking at them for program effectiveness and cost effectiveness. Sen. Allran suggested that it would be helpful to have a third party review and rate the list. Drs. Rosch and Crowley offered assistance. Michelle Hughes said other states were also looking at the WSIPP model as a possible way to create a portfolio for state investments. Sen. Barefoot noted that it was important to stop spending money after bad but rather focus on spending money after good. He offered the support of Fiscal staff. Sen. Davis also suggested Program Evaluation staff. Sen. Barefoot said at the bare minimum the state should not be paying for disproven programs that cost the State additional funds, such as Scared Straight. Not funding those is Priority #1. Dr. Rosch noted that both the Division of Public Health and the Division of Social Services work really hard on using evidence-based programs. Further support from the legislature would be a further step in the right direction.

CFTF Co-chair Karen McLeod tasked Elizabeth Hudgins and Michelle Hughes to head up efforts to prepare a recommendation for CFTF consideration at our April 7th meeting. She further commented that rather than investing in prevention, we too often wait until there is a problem. WSIPP began because Washington State wanted to reduce spending on prisons.

Perinatal Health Committee

Belinda Pettiford, co-chair of the PHC, noted that perinatal health is a complex issue that is about far more than 9 months of pregnancy or the time in the hospital after birth. The health of our babies depends in large part on the health of the people having babies – mothers and fathers – before they even know a baby is on the way. It's always important to remember that the majority of child deaths – two thirds - are to infants before their first birthday.

For our next meeting, we anticipate

- Vetting a proposal relating to one time funding for a center helping pregnant women and newborns with opioid exposure
- Learning about PQCNC's 2014 initiatives
- Hearing about what's going on with smoking initiatives designed to help pregnant women and new mothers avoid tobacco
- Receiving an update on the status of breastfeeding proposals the CFTF supports administratively
- Our next meeting is Feb 12th (The meeting was later postponed due to weather.)

At our last meeting we reported out some of the work being done to promote birth equity throughout NC. Since the future prosperity of our state depends on the health and well-being of our next generation, improving the birth outcomes and life chances of our babies is critical. But black babies born in NC are about 2.5 times more likely to die before their first birth day as white babies. Thus, figuring out strategies to reduce that gap is critical if we are going to make serious progress in promoting healthy birth outcomes for all of NC's babies.

Ms. Pettiford also explained the Life Course Model. This is a 12 step plan being used to inform federal policy and embraced by states working to promote equities. The three main areas of focus are the following:

- Improving health care;
- Addressing social and economic inequality; and
- Strengthen families and communities.

One specific action step under strengthening families and communities is to strengthen fatherhood involvement. Harkening to the IDPC theme of prevention - we need engaged fathers to promote optimal child development and build the resilience of the next generation of parents. We also need young men to be physically and mentally healthy to produce healthy babies in healthy relationships. As Rep. Fulghum pointed out the last meeting, we need to assure teens and young men are supported in healthy life choices both for themselves and for their future families.

A great deal of follow up material was requested following the meeting. That information is appended to the bottom of the Jan 6th minutes which are posted on the CFTF website under PHC.

We wanted to come back to the recurrent theme of marriage. The relationship of marriage – as opposed to co-habitation or father involvement – to improved birth outcomes and child development was discussed at the last PHC meeting. Mr. Quinn focused on the importance of fatherhood involvement regardless of marriage. Other research has looked more at marriage specifically, and we wanted to briefly share some of that info with you: Many thanks to Angela Aina, a CDC research fellow working with Dr. Sarah Verbiest at UNC for her research support. Here are some highlights:

Many positive outcomes, including birth outcomes, are associated with a healthy marriage, but it's hard to tease out what is due to marriage as opposed to other factors that often come with marriage – support, income, more hands on deck to interact with baby etc. Conversely, living with someone who is abusive or who smokes or has certain other behaviors can be negative for fetal and child development. (Links are provided for the minutes but sources were not cited during the meeting.)

- Intended pregnancies tend to be healthier. Pregnancies conceived within marriage are more likely to be intended.
- Married women are less likely to be young teens.
- Birth outcomes tend to be better when mothers are have emotional, financial and other support. Husbands can be an important source of such support.
- Nationally, birth outcomes tend to be statistically significantly better for babies born to married women. However, the data does not control for other factors, such as income, domestic violence and other factors. http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_08.pdf - see pages 13 and 39)

Research on the child development side of the equation suggests it is not just marriage per se that conveys the benefits.

- **Parenting style matters more than marital status.** One recent study looking at low-income children found that fathers' warm and stimulating parenting predicted enhanced reading and math skills for children in middle childhood, whereas fathers' restrictive discipline predicted lower reading and math skills, especially for fathers of color, regardless of marital status. ***Does Early Paternal Parenting Promote Low-Income Children's Long-Term Cognitive Skills?*** http://jfi.sagepub.com/content/32/11/1522
- **Cohabiting fathers are as likely to be involved with the children.** Cohabitating and married fathers show similar involvement with the children, at least for black fathers. *Resident Black Fathers' Involvement: A Comparative Analysis of Married and Unwed, Cohabitating Fathers* http://jfi.sagepub.com/content/33/6/695

Jeff Quinn presented on the importance of fatherhood and the work of the Fatherhood Initiative and Fatherhood Council. Key points included the following:

- When fathers are engaged in positive ways, child development outcomes are stronger
- Two decades of work have contributed to development of programs and infrastructure to strengthen father involvement, but resources are dwindling
- Too often programs and social norms see fathers as an "add on" rather than central
- Fatherhood is relatively newer in the study world and lacks the strong evidence base that some other programs have. Best practices include the following:
    - Readiness
    - Program format
    - Staffing and preparation
    - Staff considerations
- Identifying fathers expansively beyond just the biological father.
- Positive fatherhood is hard to define concretely but it includes co-parenting, being a good role model and contributing materially
- Quality time is more important than quantity
- When fathers are engaged, documented benefits included positive socio-emotional and cognitive development as well as educational success

Too often society and programs unwittingly create barriers to father involvement. Rather than discounting dads, we need to have explicit conversations about the expectations of all parents for the best way to raise the child. To move forward we need to promote social norms change, use research to inform practice, and make use of existing resources.

Rep. Fulghum asked if the Fatherhood Advisory Council emphasized any spirituality or religious factors. Mr. Quinn explained an effort in conjunction with the Durham Partnership for Children where they interviewed key informants from 50 churches in Durham that provided services to families and children to see how much they included fathers in their efforts. The Advisory council is working to involve the faith community more in their efforts.

Sen. Bingham asked how many fathers seeking help from the Council or Initiative were divorced. Mr. Quinn responded that the programs don't ask; rather the focus is encouraging positive interventions with the child.

Dr. Labbok with the Carolina Global Breastfeeding Initiative at UNC-CH noted that research shows that father support was an important factor in breastfeeding decisions of the mother.

Sen. Barefoot asked if father was viewed separate from marriage. Mr. Quinn noted their focus was on fatherhood, not marital relations.

Sen. Barefoot asked about the impact of video, including video communications, on cognitive formation, including American Academy of Pediatric guidelines. Mr. Quinn noted they encouraged fathers engage with children face to face or over the phone; they had not looked at Skype (etc.) specifically. They were working on a grant with Fort Bragg on helping deployed fathers use technologies to stay in contact with their children. Dr. Morris noted that the NC Pediatric Society was highly engaged on the video issue.

Effective Current NC Laws for Prevention of Child Death and Injury

Dr. Steven Marshall presented on efforts of the Injury Prevention Research Center at UNC-CH to create a tool for policy makers and others to assess the impact of various policies towards preventing injury and death. The tool – available at injuryfreenc.org starting later this month - will look at policies affecting all age groups. It will explain the known science and policy impact. A problem may be well documented (traumatic brain injury, for example), but the policy solution may be less clear.

Dr. Marshall lifted up the example of motorcycle helmets. For example, analysis from CDC shows that NC leads the nation is cost savings from helmet laws. Treating brain injury is very expensive. NC's universal helmet law makes it easier and more likely for law enforcement to enforce. That combination has helped avert state costs due to treating expensive brain injuries resulting from motorcycle collisions. More information will be available once is a study is completed comparing costs from treating motorcycle-related brain injuries in NC (which has a universal helmet law) and SC (which lacks a universal helmet law). Dr. Marshall noted that costs are complicated and not all costs accrue to the State. (Families, private insurance, employers, etc. all pay part of the cost of a brain injury, for example.)

Sen. Allran clarified that NC's motorcycle helmet saved more money than any other state. Dr. Marshall said yes; yet every year there is an attempt to repeal it. Dr. Fulghum noted, based on his clinical experience injuries were often devastating, especially when the rider was unhelmeted.

Sen. Davis inquired what about NC's specific law made us the leader for cost savings since other states have universal laws as well. Dr. Marshall noted it was many factors, including the facts that NC has a universal law, many motorcycle riders and many months of the year when motorcycle riding was pleasant. Sen. Davis asked if the numbers could be converted to rates. Alan Dellapenna noted that Dr. Rob Foss at the Highway Safety Research Center noted the importance of exposure and the importance of looking at miles traveled. It can be hard to compare states; therefore it can be helpful to look at states before and after enactment/repeal of helmet laws.

Sen. Bingham asked if there were federal or state standards for equipment. Dr. Marshall noted there were federal standards, but not all states that required a helmet required one that met federal safety standards. (NC's law does.)

Director's Report

Elizabeth Hudgins reported that she was in the process of interview possible summer interns. Both had access to alternative funding sources. Also, a project looking at resiliency indicators has been accepted by the Sanford Institute at Duke for graduate students to analyze. She also re-iterated Ms. McLeod's statement encouraging members to be involved with at least one committee.

Announcements

Alan Dellapenna added that Ms. Hudgins also represented the CFTF at the Local Health Director's conference the previous week, talking about prescription drug issues.

The CFTF adjourned upon motion by Sen. Barefoot.

LONGSCAN SCREENING TOOL CRITERIA

The High Priority Infant Tracking Program (HPIP) tool was used in North Carolina in 1986 with newborns who were disproportionately selected to be high risk. Screening elements included

Mother with less than or equal to a high school education;
3 or more children in the home;
single mother;
mother less than 18 years of age or greater than 35 years of age at the child's birth; mother's history of abuse;
receipt of WIC, Medicaid or AFDC;
less than or equal to $15,000 household income;
maternal depression;
low maternal self-esteem;
and unsafe neighborhood.

In a cohort of children at-risk, the tool predicts with 93% accuracy that an at-risk child by the time he/she reaches his/her 18th birthday is characterized by experiencing one or more of the following three outcomes:

1) Child was reported for child abuse or neglect;
2) Child self-reported to an interviewer that they had been abused or neglected; or
3) Child witnessed interpersonal violence in the home or neighborhood