Trinity Health
Of New England

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Narrative Report

Child Safety Forward Initiative:

Reducing Child Fatalities and Recurring Serious Injuries Caused by Crime Victimization

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Project Overview

Child Safety Forward: *A National Initiative to Reduce Child Abuse and Neglect Fatalities and Injuries Through a Collaborative, Community-Based Approach*

The U.S. Department of Justice, Office of Justice Programs, and Office for Victims of Crime funded a three-year (2019-2022) demonstration initiative to develop multidisciplinary strategies and responses to address fatalities or near-death injuries as a result of child abuse or neglect through a collaborative, community- based effort. Saint Francis Hospital and Medical Center in Hartford, Connecticut, was one of five demonstration sites chosen for this grant nationwide. The other sites included: The Indiana Department of Health; Cook County Health, Illinois; Sacramento County's Child Abuse Prevention Council, and the Michigan Department of Health and Human Services.

The Hartford project area is an outlier when compared to Connecticut and national child maltreatment rates. From 2015-2017 Hartford averaged 17.6 substantiated cases of child maltreatment per 1,000 children, nearly double the state (9.4/1,000 children) and national (9.1/1,000 children) rates during the same period. This and other disparities evident in the data demonstrate the need for an effective child maltreatment intervention and prevention system.

The Hartford site is unique in the field and among the demonstration sites in focusing on parent and community organizing and the purposeful shifting of power to those most affected. This project combined the disciplines of research, community organizing, and prevention education. The leading beliefs for the Hartford site were:

Nothing about us without us

Plan *with* people, not *for* people

Those closest to the problem are closest to the solution.

This project was led by a Parent Engagement Work Group: Those closest to the problem.

Hartford's Child Safety Forward project brought together a multidisciplinary team of stakeholders composed of state agencies; community-based organizations; and, most importantly, parents to share data, coordinate services, facilitate community participation, and seek best practice recommendations.

In July 2019, the Child Safety Forward team developed the following list of things it hoped to learn from the community data collection:

- Risks for child maltreatment, contributing to repeated injuries and fatalities
- Cultural strengths and protective factors in underserved populations
- Parent and community responses to educational materials distributed by public and private agencies
- Access to prevention education
- Effectiveness of prevention messages
- What communities believe can prevent repeated injuries and fatalities

- Cultural and religious practices that are used to protect children; how they can be used to design and deliver prevention education and services
- Beliefs and attitudes toward CPS

We sought to learn practices used in communities to respond to suspected child abuse:

- An individual's history of childhood victimization, including the response of caregiving adults and authorities
- Knowledge of child injury and fatality risks
- Knowledge of protective factors
- Knowledge of CPS purpose and procedures
- Likelihood of reporting to CPS
- Likelihood of reporting to law enforcement

This document lists learning from weekly meetings and additional meetings and communications with the eight parents who composed the Parent Engagement Work Group, as well as other communications with community members. In addition to responding to the list above, this document addresses further learning from parents and the project overall. Other lessons learned are addressed in the retrospective data review and community data collection.

The Parent Engagement Work Group was developed in three phases:

1. In phase one (year one), the Project Coordinator recruited parents from existing relationships in the community and with the Family Advocacy Center at Saint Francis Hospital. Some were outreach volunteers who received a stipend to identify victims of crime in their specific communities. Mothers from this project represented Muslim women and Jamaican/Caribbean/West Indian women. Another was a member of Hartford Parent University (HPU), a grassroots organizing agency that trains and supports parents to advocate for quality education. In phase one, the Parent Engagement Work Group began attending and making reports at stakeholder meetings. They were introduced to state agency leaders, child abuse pediatricians, community agency directors, and other providers. They initially expressed some reluctance and intimidation about addressing people labeled as "experts." Parents also conducted education and outreach on safe sleep activities in their communities and participated in educational sessions with Saint Francis Hospital employees and patients of the OB-GYN clinic.

2. Phase two started with the first test focus groups (one in English and one in Spanish) about 18 months into the project. Additional parents expressed interest in the Parent Engagement Work Group. The test focus groups identified the need for proactive, comprehensive child safety and well-being education delivered in safe spaces by trained parents.

3. Phase three began with the infusion of more parents from Hartford Parent University and intentional outreach for referrals to represent parents of children at increased risk for harm. These categories included children with disabilities, children of immigrants, and LGBTQI children. Hartford's demographics already assured African American and Latinx representation. An effort was also made to recruit teen parents and fathers. One father joined the group and remained. One teen mother accepted the invitation but was unable to participate.

Lessons Learned: Cultural Strength & Protective Factors

What are the cultural strengths and protective factors in underserved populations?

Parents listed the following:

- <u>Communal identity, a sense of *our people*</u>, as opposed to strong individual identities, was listed as a cultural strength of all communities represented in the group (Jamaican, Puerto Rican, Dominican, African American). Parents noted living in neighborhoods where people know one another and see what is happening. They also noted closeness within families, a tradition of mutual support, and knowing that families and communities are interdependent. A few parents told stories of helping strangers they encountered in their communities who were in need.

- <u>Values of sharing and generosity were noted as strengths/protection.</u> Examples included feeding and clothing children of parents on drugs. This was seen as preferable to calling DCF or other authorities.

1. <u>Cultural and religious practices that are used to protect children and how they can be used to design and deliver effective prevention education and services.</u>

- No specific religious practices were mentioned, but emphasis was placed on faith and prayer.

- Cultural practices included multigenerational living and childrearing. Parents said that education must address grandparents, aunts, uncles, and other members of extended families, not just mothers and fathers.

- Parents stressed that money and material gain are not a priority in the cultures represented. As a matter of fact, there is disdain for valuing money first. Parents were proud of their cultural value of sharing and valuing "people over profits," as one mother put it.

2. <u>Practices in use in communities to respond to suspected child abuse.</u>

<u>Do what you can to support children, using extended family and community members.</u>

Examples:

- Feed children whose parents are addicted or for other reasons don't or can't feed them
- Provide clothing and other material goods that are needed
- Let them sleep or even live in your home if violence is occurring
- Talk to the children, letting them know they are loved
- Refer the children/family to churches, food pantries, and/or community-based organizations that may be able to help them

- Talk to the parents who are neglectful or abusive and try to find someone they may listen to, although this is not always possible
- Do all the above and pray for them

For consideration: When kinship placement is not possible, perhaps parent engagement groups in neighborhoods can identify helpful neighbors that the child knows and trusts, having already received informal support from them. CPS may consider having parent engagement groups identify such people and work to certify them as foster parents.

3. Parents' history of childhood victimization, including the response of caregiving adults and authorities, served as a motivation to protect children.

Several members of the group reported childhood victimization by either caregiver and/or others. They also reported experiencing domestic violence as children and adults, as well as community violence. Several were affected by the childhood victimization of members of their families. One parent identified herself as the cousin of "Baby Emily." Baby Emily was a famous (1995) case in Hartford that prompted changes in the CPS system. After many calls from family and friends to police and CPS involvement, the stepfather of this 7-month-old child raped and killed her. This parent spoke of how the murder of their infant cousin still affects family members, including how they parent and that she will not let men be around her daughter. She was 14 when Baby Emily was killed. All members had stories of trauma and noted the need for therapy for direct and more distant family members who are affected.

4. Parents' lived experience as protective factors.

Without all having formal knowledge of protective factors, these parents all act as protective factors. Four of the original eight parents are members of Hartford Parent University, a grassroots advocacy and educational project for parents of children in Hartford Public Schools. Others have experience as community activists. The Parent Engagement Work Group is largely a gathering of leadership/leadership potential parents and grandparents.

Examples of how these parents/grandparents serve as protective factors include:

- **Parental Resilience:** Every parent has and continues to overcome significant challenges. Four of the original eight parents have disabilities. They see themselves and thus live their lives as valuable, capable people. Three of the parents have a child with a disability for whom they are fierce advocates. Other parents are in long-term recovery from addiction. Most have survived either sexual and/or intimate partner violence.

- **Positive Social Connections:** Most Parent Engagement Work Group members' children were active in the community and extracurricular activities, such as Boy Scouts and Girl Scouts, the Boys & Girls Clubs, art and music programs, police and fire cadet programs, sports, and other activities. Most parents were connected to a house of worship and to civic and social organizations and were active in community organizing and/or local politics. By and large, these parents are the ones that members of their communities call upon for support. While the single father was an exception to this pattern, being new to all the organizations and programs, he had involved his children in community and school activities.

- Some families were currently using mental health services.

- **Knowledge of parenting and child development:** Those who were also members of Hartford Parent University had some formal knowledge of parenting and child development by taking classes offered by Hartford Parent University. Others had taken it upon themselves to ask questions of school staff or to do online research. Some had learned about parenting and child development in therapy or by working with their child's therapist or medical provider. This includes parents of children with disabilities working on learning about their child's disability.

- **Goal Setting:** All parents in the Parent Engagement Work Group were goal-oriented, having established and met goals and continuing to set further goals. Goals included recovery from addiction, leaving unhealthy relationships, educational goals, training and employment goals, health goals, and goals for managing disabilities. One mother, a survivor of multigenerational sexual abuse, living with Sickle-Cell Disease and unable to work full-time, was writing and publishing books to prevent child sexual abuse. Another member was in the process of organizing a fashion show for adults and children with disabilities.

Lessons Learned: Risks for Child Maltreatment

What are the risks for child maltreatment, contributing to repeated injuries and fatalities?

Perhaps the greatest area of learning on this topic was parents' perceptions of risks. Early in the formation of the Parent Engagement Work Group (October 2019), parents made it clear that they wanted to address issues beyond child abuse and neglect by caregivers, noting that there are many environmental, systemic, and other types of threats to the safety of children. Examples included non-caregiver abuse and exploitation, drugs, suicide, and community violence. They wanted to address all factors contributing to repeated injuries and fatalities. After consulting with the technical assistance lead, the project thus shifted to address all threats to child safety and well-being.

The Parent Engagement Work Group identified loss of and reduction of services during the COVID-19 pandemic as a risk factor.

They specifically gave the following examples:

1. The closing of the Injury Prevention program at Saint Francis and other hospitals.

The service was suspended at the start of the pandemic. Other hospitals and institutions closed similar services during the pandemic. The parents in the group were mostly patients of Saint Francis Hospital. The Injury Prevention Program provided free infant car seats and provided education about proper use. The social workers in Saint Francis Hospital's OB-GYN department noted that they called several places, including police and fire stations, to find that no one was teaching car seat safety or giving away car seats. The injury prevention program also taught "Stop the Bleed," CPR, "Let's Not Meet by Accident," accident prevention education, and bicycle safety, including the distribution of helmets. Parents noted that the sudden cessation of these services increased the risk of injury and death, especially the lack of access to free child car seats. Perhaps most notably, parents were not notified of the end of such services, and there was no effort to make alternate plans with families. The programs at Saint Francis Hospital and other places in the community are currently being resumed. It is likely that fire and police departments ceased direct services to the public at the start of the pandemic as well.

2. The 211 information was outdated and often inaccurate.

This was especially true at the start of the pandemic. Many programs closed during the pandemic, a time when families felt stressed and more vulnerable and when in-school services were not available. Social workers from Saint Francis Hospital's OB-GYN department validated the problems with 211, saying that they called the referral sources given by 211 before referring parents to be sure the programs were still operating. One social worker noted that she was referred to the fire department to teach proper car seat installation. The fire department referred her to the police department, which referred her to the Children's Hospital. None of these places were able to meet the needs of her patient for a free or low-cost car seat and instruction on proper use. One parent noted that while car seats and related education were not available, parents were still held accountable by law and CPS. She gave the example of her friend, who was stopped by police because her infant was not in a car seat. She was mandated to a class on car seat safety, given a car seat, and taught to install it properly. The woman telling the story noted that, even more now, during the pandemic, the only way to get certain resources was to do something wrong or be suspected of doing something wrong.

3. The Parent Engagement Work Group noted the reactive manner in which child safety education is provided as a risk factor.

Parents said that the most likely way they will receive child safety education is when it is mandated by CPS after an allegation of abuse or neglect. They did not know of other places to access such education. Parents reported that they and their communities mostly thought of child safety education as reactive and punitive. They noted that when such education was mandated, it was on the one topic identified in an allegation. They asked if there was a comprehensive curriculum/program and if it cost money to participate. They wondered if perhaps people with more money could access comprehensive child safety education. A single father of four children, one of whom is autistic, stated that he needed help for over a decade for his disabled son and felt that because he had never abused his children, he had never been offered education or support. He works as a school bus driver, which allows him more time with his children but limits finances. He listed things he felt were a threat to his disabled child's safety and well-being, including some treatment at school, stating that he had to figure out everything himself. He expressed ongoing concern about the well-being of his child with autism, saying that he is ignoring the advice of some school personnel to put his son in a group home. This writer notes that while no one in the group felt they had adequate resources, the one Black man in the group had not been offered anything and was not aware of any resources.

4. Lack of awareness of programs and services was listed as a risk factor for injury and death.

Several parents of children with disabilities were surprised to learn of the services and educational programs available to them. Over and over, parents asked why they had never heard of these programs. Staff explained that nonprofits lack funding for marketing, noting that everyone knows about soft drinks and unhealthy snacks due to advertising, but service and education programs usually lack the budget and talent to make communities aware of their services. Once again, parents noted that they were likely to find out via a referral after someone thought they were "doing something wrong."

5. Access to data about threats to child well-being/safety in their communities.

Parents reported that they were unaware that so much data was collected about their families and communities. Responses included surprise, resentment, and curiosity about how such data was collected, analyzed, and interpreted.

Parents and community-based organizations expressed anger that they had not been made aware that the death rate of Black children is two times that of white children. They asked how people who were not members of their communities (not just racially/ethnically but socio-economically and culturally) knew more about their collective reality than they themselves and made plans *for them* without communicating with those directly affected. Community-based organizations represented on the stakeholder group stated that they work with state agencies and other providers, sit on committees and advisory boards, and were incensed that no one told them of the rate of death of Black children. They felt that “an alarm” should have been put out to bring them together to address this emergency.

- *All* data presented throughout the project was brand new to *all* parents. This included data on rates of child death and causes of death, CPS cases per municipality (Hartford compared to suburban towns), reports and substantiations, data from law enforcement, the US Centers for Disease Control, CPS, the State of CT Medical Examiner’s Office, Connecticut Office of the Child Advocate, and data from journal articles.

- Parents asked many questions about the data, including if and how they could be involved in planning and carrying out research on their own communities and then using that data to plan improvements for child, family, and community well-being.

6. Disproportionately affected and underserved communities do not believe the prevention messages they receive.

Parents said they did not believe CDC and other recommendations on safe sleep because:

- Mothers said they received conflicting information from lactation specialists, who told them that it was okay to sleep with their babies, although OB-GYN staff told them not to sleep with their babies.

- Jamaican immigrants said that American safe sleep education contradicts the emphasis by Jamaican providers on the importance of skin-to-skin contact that encouraged them to co-sleep.

- One parent raised the concern that not sleeping skin to skin could cause psychological problems for the child later. The parent questioned, “Is it better to risk a rarely occurring SIDS event or to establish a loving connection early in the child’s life?” She noted that newborns are shoved out of the only home they have ever known, their mother’s womb. How healthy is it to shove them further away from that home by separating them from their mother’s body? The group noted that this is not addressed in the safe sleep literature they have seen.

- Jamaican and Puerto Rican mothers said they had been taught to put their baby on the stomach or prop an infant up on its side to avoid strangulation on vomit. Strangulation on vomit needs to be addressed in safe sleep education.

- When asked about receiving prevention education materials, members of the Parent Engagement Work Group, clients, and staff of community-based organizations responded:

    - I didn’t get this (safe sleep) literature when I was in the hospital.
    - What information?
    - There’s no time to read with doing the rest of my life.
    - I just don’t usually pay attention to written information. I’m more likely to notice it on a TV or a radio announcement/commercial.
    - Literature was associated with a CPS case, not received beforehand.

Parents, overall, did not believe the information in safe-sleep literature.

They thought that some parent education was applicable to Black and brown children but that things like "time out" might work for white children but not theirs. Several parents stated that Black and brown children require physical discipline. This theme occurs in other discussions with parents and is discussed in other sections of this report.

7. What these communities believe can prevent repeated injuries and fatalities.

- Comprehensive, proactive peer education and support provided in safe, friendly, non-threatening spaces. Parents had a lot to say about this! They first brainstormed and then planned a list of topics on which they requested training and education. They soon started planning to develop a comprehensive child safety curriculum for which they would be the trainers. The curriculum/educational guide is to be delivered in psychologically safe community spaces such as recreation and community centers.

- Stop illegal guns from coming into their communities.

- Adequate, quality addiction treatment, provided upon demand.

- Closer community caring and communication.

- Efforts are needed to reduce the stigma associated with mental illness and addiction in Hartford's cultural and other identity communities (such as LGBTQI, disability, religious minorities, etc.). Part of the plan to reduce stigma is addressed in the curriculum/educational guide. Parents are interested in community research that can inform how to reduce such stigma and help families accept mental health services. This writer notes that the shame associated with marginalized identities is further increased by the stigma of mental illness and addiction.

- It is necessary to make safer spaces for undocumented immigrants to receive services. One suggested strategy is spreading the word in immigrant communities about sanctuary and asylum spaces, such as health care, sexual violence, and intimate partner violence services. Parents agreed that organizing and advocacy are needed in this area.

8. Beliefs and attitudes toward CPS.

- Fear was prominent. While some parents knew that CPS did not exist for the primary purpose of taking children away, they still feared that this could happen, even if unwarranted.

- Youth from Hartford Communities that Care shared examples of having good experiences with CPS. They stressed the need to share them to help people utilize the agency's services.

- There seems to be a strong and widespread belief that it is illegal to spank or discipline children, as per CPS. Parents in the Parent Engagement Work Group and in the community fear that following what they believe to be CPS "rules" will result in unruly children likely to be in trouble with the law and subsequently later injured or killed by police. Variations of, "I'm beating you now, so the police won't beat you later" was frequently heard in discussions the principal investigator had with parents and community members.

- CPS involvement will make things worse over the course of a lifetime. This comes from testimonies of community members who grew up in foster homes. A common phrase in Hartford is "Once DCF gets in your life …" This is one of the reasons why it is considered immoral to make a report to CPS. CPS is seen as the very last resort. While it is also a common value *not* to call or talk to the police, parents preferred calling law enforcement to calling CPS. This principal investigator has heard Black and brown DCF workers say that they would never make a report to DCF on friends or family.

Additional Lessons Learned by the Research Team

In addition to the questions posed by the research team, additional lessons were learned.

1. Structure and best place for project to live.

Structural patterns that support the provision of clinical medical services, or other large-scale corporate practices, sometimes make working with and on behalf of grassroots people and organizations difficult. Trinity Health is a national corporation comprised of more than 90 hospitals in the U.S. Saint Francis Hospital merged with Trinity Health in 2015 and gradually changed its policies and procedures to match those of this health care corporation. These changes were amped up at the start of this project. A major issue was the payment of invoices. Payments moved from being made by the hospital's finance department to a central location in another state, responsible for paying invoices for more than 90 hospitals. The system simply cannot move quickly. Paying large medical supply companies and similar vendors is different from working with small/local/minority vendors for services, food, and supplies; ordering gift cards; or paying stipends to program participants. The system also cannot pay contractors in a timely manner. This showed up as a threat to trust when parents planned to use payments/gift cards for Christmas, and they did not show up until the spring. Some had a hard time understanding that there was no one local person with a checkbook in their desk. One parent refused to come to meetings until he was paid.

Other complications that may not show up in standalone organizations relate to policies that reinforce an "us and them" mentality. For instance, training opportunities for "colleagues" are not open to community members. In some smaller community-based organizations, it is possible to invite community members to train for staff members and volunteers. Some parent and staff suggestions had to first be researched to see if certain actions complied with company policy. This sometimes meant going through several layers of hierarchy, through regional or even national strata, to determine what could be done. A project such as one that seeks to shift power to parents as leaders and decisionmakers rather than advisors needs both a strong infrastructure as well as flexibility and the ability to respond quickly.

2. Need for a mixture of funding.

Some of the restrictions and rules tied to federal funding suggest that a mix of public and private funding best suits community-rooted projects and movements. Federal funding generally does not permit buying food, yet food is a basic organizing tool. Similarly, some federal contracts forbid paying stipends to participants. Saint Francis Hospital supplemented federal funding to provide food for some parent and community gatherings. DOJ-OVC utilized a developmental evaluation model and encouraging sites to shift direction based on lessons learned also required budget revisions. This did not pose unsurmountable problems but certainly kept financial and administrative staff busy. Family and other relatively small foundation changes in line-item spending can often be accomplished with a phone call, thus supporting a developmental evaluation model.

3. Leadership and all involved need to understand federal funding and the program model.

An understanding of the various types of federal contracts and agreements is critical in carrying out a project such as this. The meaning of a cooperative agreement was not initially understood by some corporate leaders and was the cause of tension at one point.

The developmental evaluation model is vastly different from the logic models and other tools that dominate the field of medicine, finances, and other disciplines. A data expert assigned to the project consistently advocated leadership for the project to be more quantitative and conform to more traditional research models, causing some delays and inhibiting progress. This project was in a department led by the vice president of compliance. However, the expectations and norms are vastly different from the model for this project.

4. <u>Cultural congruency and communication.</u>

The hierarchical culture and structure of large state agencies or corporations may discourage parents from leading and playing a central role in decision making. This is not a foregone conclusion. It is important to consider and understand the freedoms and limitations that culture and structure place on those who are usually “planned for” to lead in planning, as opposed to only suggesting. The cultural manner of many, perhaps most, organizations dictates that a greater demonstration of assimilation with the dominant corporate culture equals greater professionalism and credibility. For instance, the value of brevity, and soundbites may not support the depth and time needed to hear stories that critically inform exploratory research. Exploratory research may inform the need for further research into uncharted areas with larger samples of statistical significance. Additionally, psychological safety may be threatened by unfamiliar and uncomfortable corporate/government cultural norms that call for people to sharply separate their feelings from their thoughts. A plan should be made to accommodate real-time limitations, other conditions, and psychological safety. A part of this may well be budgeting for staff and volunteer time that accommodates parents bringing their whole selves to the experience.

When first called upon to speak at stakeholder meetings, parents demonstrated reluctance and nervousness, saying less and speaking in much lower tones than in parent meetings. Parents stated that they were insecure and intimidated when talking to “people with all those degrees.” Staff reminded parents that many of these stakeholders are also parents and family members who may have insecurities about addressing them adequately. They also were reminded that these stakeholders spoke differently in their personal lives.

Having stakeholders or representatives of their agencies make presentations to parents seemed to increase parents’ confidence. One such factor may have been the ratio of one presenter to six to eight parents. In these venues, parents questioned the presenters, even doubting their accuracy. In one situation, a parent corrected the presenter. The parent was correct, but the presenter was incorrect. These presentations not only educated parents but also increased their confidence, as evidenced by their speaking more and more confidently in stakeholder meetings. At a peak point of demonstrated confidence, parents asked to be leaders in planning the agenda of stakeholder meetings. Other factors that may have increased parents’ confidence and assertive communication are:

- Assigning parents tasks and roles usually reserved for staff, including being timekeepers and notetakers at meetings and having parents edit documents created by staff, such as the job description for the Parent Engagement Work Group. Parents were given the version submitted with the funding application, and they revised it to be more understandable to their peers and to reflect their vision. Parents were given other documents and reports to review and edit. They created the educational curriculum, and staff edited and formatted it, and then parents reviewed it again. In short, treating parents as decisionmakers rather than advisors may have supported increased participation with “professional” stakeholders.

- Perhaps two-way training in ways of communicating and conducting business would help ease the sometimes-counterproductive communication gap between community members and representatives of government and traditional corporations/providers. One of the more difficult realities of this work is acknowledging the “different languages” and the assumed superiority of one language over another. While not intended, language serves as a weapon to keep the less educated and less assimilated “in their place,” resulting in intimidation, resentment, and dangerous distance that inhibits learning by policymakers and institutional leaders as well as learning by community members. For example, we attempted to ban the use of acronyms in meetings with limited success. A more successful tactic was to have assigned people to ask for an explanation every time an acronym was used.

Lessons Learned by Parents

Feedback on Educational Presentations

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1. Overview of Child Death.

(Presented by the Office of the Child Advocate)

Parents said to have learned the following:

- About the existence of the statistics from the Office of Child Advocate and that the majority of the deaths had been labeled undetermined.
- A large percentage of pre-adolescent and adolescent deaths are "undetermined."
- About the existence and composition of the Fatality Review Board.
- Data can tell different stories, depending upon how it is organized and presented. The presenter from the Office of the Child Advocate's bar graph showed 0-1 years of age as the highest rate of child death. The project's principal investigator noted that if you added the number of deaths in adolescent years, it exceeded the death of infants and asked parents to think about this. They wondered what initiatives are being taken by state agencies to address the preventable deaths of adolescents.
- Data is not available in real-time.
- The Office of the Child Advocate is not adequately staffed to provide data to the public in the manner and timeframe that parents requested and is severely challenged to oversee the safety and well-being of children in the care of/receiving services from state agencies. Parents questioned if they should be advocating for increased funding for the Office of the Child Advocate.
- Although state agencies are funded by public dollars, all data is not accessible to the public.

Discussion:

- Parents suggested that if communities were made aware of the causes of child death and other relevant information, they could help recommend prevention methods and policy change. Every death likely points to dangers in the community that threaten the well-being and lives of other children. If community members know, they can act on the ground.
- Parents are uncomfortable with the number of "undetermined" deaths and want to understand more about it.

- Parents said they wanted to develop a project to collect data about dangers to children and use it to make recommendations for change.

2. Safe and Unsafe Sleep.

(Office of the Child Advocate and CDC information presented by Project Coordinator Chavon Campbell)

Parents did not report so much on lessons learned as they discussed the information presented.

Parents questioned the safe sleep guidance:

- In Jamaica, medical providers/educators stress skin-to-skin bonding. What is the long-term psychological risk to physically separating an infant from its mother during sleep? Safe sleep educators need to address this and other doubts that parents have.
- Jamaicans and Puerto Ricans have been taught to place an infant on its stomach or propped on its side to sleep to avoid choking on milk or formula and thus dying.
- Parents were not previously aware of sleep compartments that can be put in or next to the parent's bed.
- Parents discussed how lactation specialists told them that it's fine to sleep with babies, but OB-GYN providers told them not to sleep with their infants.

3. Domestic Violence.

(Presented by Hartford Interval House - Domestic Violence Shelter in Hartford)

Parents reported learning the following:

- Technology makes it easier for people to get stalked.
- An app that can track your phone or keys if you lose them-this could put some victims in more danger if the abuser uses the app to find them.
- Two parents said they prefer paper documents to digital ones and technological assistance. They appreciated that the guest speakers brought hard copies of documents and did not refer them to an online source.
- 22-28% of men are being abused. This was an eye-opener for some parents. Victimization occurs in heterosexual and homosexual relationships. They said that services for male victims need to be more widely advertised.
- Some families stay in a domestic violence shelter for up to a year. It depends on the individual circumstances. Parents did not know that long-term support and shelter were available.

- 6,000 domestic violence cases were reported in Hartford.

- A mother said she could have utilized services if she knew about them.

- A father said, and everyone agreed, this needs to be talked about in school. He said verbal abuse starts in school systems, like with bullies. He said everything should start in the school system.

- Parents discuss how cultural beliefs impact abuse. All cultures have some form of abuse and similar yet different ways of viewing it, mostly blaming women.

- A father said a lot of abuse could be triggered by drugs and drinking, money, stress, and pressure. We can educate the community and we can take this stress off of people by:

    - Letting people know they are not alone.
    - Letting people know about services and word of mouth is a way to do it and is a personal way to let people know they aren't alone.

Parents shared their thoughts on how domestic violence impacts children:

- It impacts the children very much. A mother shared her experience with the emotional difficulties of her son blaming her for making his abusive father leave home. She said now that her child is older, he understands more. She said she set up services for her child and that she struggled, lived in shelters, and got PTSD, but what matters is that her child is safe. She stressed the importance of getting services for children as well as adult victims.

4. Sexual Abuse/Assault/Sex Trafficking.

(Presented by Greater Hartford Family Advocacy Center Forensic Interviewers)

Parents said to have learned the following:

- Men are sexually abused, assaulted, and trafficked.

- About the grooming process.

- About the services of the Family Advocacy Center. A victim can have a forensic interview by a clinician and the police can observe it, as an option to being interviewed by police at the station. They discussed the need to know about services like this without having to be referred by DCF or the police.

- How parents were already aware of the damage of sexual trauma from their own experiences and those of their loved ones. One mother expressed the pain of seeing her daughter's active drug addiction, knowing the connection to childhood sexual abuse. She mentioned that this adult daughter also has bipolar disorder. Another parent, who is in long-term recovery from drugs and sexual abuse, offered her phone number to support the mother and to reach out to the adult child.

- About of groups and individual therapy resources available to them. This includes Spanish-speaking clinicians and clinicians from Jamaica who understand their cultures.

- The Sexual Assault Crisis Service offers a certificate course to become a Sexual Assault Counselor. As a counselor, you answer a hotline and talk to victims. You can also use this skill in your community.

- A parent who volunteered in a DCF community program complained that training on sexual abuse and other useful topics through the DCF academy was not accessible for volunteers, only for paid DCF staff. This training is needed by people who live in the community and can pass it on daily to their neighbors, friends, and families.

- One person mentioned the cost of some great conferences and the need to include parent training in the project continuation budget.

- How sharing our stories is an effective and powerful tool for reaching out to others to connect them to services.

5. Mental Health.

(Presented by clinicians of the Greater Hartford Family Advocacy Center)

Parents reported learning the following:

- You can and should talk to different therapists to find the right one for you. “Therapy is like shoe shopping. You aren’t going to pick out the first pair of shoes you see when you walk into a store. You are going to shop around and see what best fits you.”

- Victims of crime can get therapy from the Family Advocacy Center at Saint Francis Hospital. Parents learned that all services are free and that one doesn't need insurance.

- Different therapists specialize in different things. You can ask for one who specializes in your area of need. Ask therapists about their trauma training.
- About frontal lobe (brain) development and that there are tools to assess it. Psychologists can conduct cognitive assessments that explores executive functioning. There are questionnaires that explore areas of impulse control, organization skills, problem-solving skills, etc.

- To get a young child assessed, talk to their school.

- An adult needing an assessment should contact a psychologist. The Family Advocacy Center and other mental health programs can help make referrals.

- "I was pleasantly surprised to learn of a Jamaican psychologist and Jamaican therapist (two of three presenters). Culturally competent mental health services are needed in the Caribbean West Indian community."

- The parent group can help make people aware of these services in underserved communities, such as the Jamaican community.

- Parents who have successfully advocated for their children to get appropriate services can teach other parents how to advocate for their children. The mother of a transgender child offered to let others know about specialized therapists and psychologists that have worked with her child, who also has mental health diagnoses.

- One reason some children have so many therapists is that interns are assigned to their cases. Parents complained that as soon as a child started to open up to one person, they were switched to someone new. Parents realize that interns need to learn but not at the expense of a child's engagement and treatment. Parents learned that they can and should ask if the therapist is an intern and how long they will be available to work with a child.

- It's fine to tell a therapist that you don't think your child is getting what they need. If the therapist isn't open to this conversation, perhaps another therapist is needed.

- "We could record the testimonials in this meeting to make a perfect mental health awareness video(s) for parents and to educate mental health professionals."

- Eye movement desensitization and reprocessing (EMDR) is a specific therapy that helps folks think about their trauma while reducing their feelings surrounding it.

6. Effective Parenting

(Presented by Family Advocates of the Greater Hartford Family Advocacy Center)

Parents reported learning the following:

- About the Triple P (Positive Parenting Program®) and Circle of Security® early intervention program. Only one parent already knew about it and is Triple P Certified. Other parents expressed interest in training to be Triple P and Circle of Security certified. They also want to know about other certification programs that can benefit their education, employability, and advancement. The Sexual Assault Counselor Training was mentioned and that they would seek funds to pay the tuition for this and other certifications for parents. Parents mentioned that, once again, effective parenting training is mostly available to parents suspected of abusing or neglecting their children. They discussed that they want to spread the word about parent education programs, especially through the schools.

- Parents asked why grant-funded prevention education programs have target numbers of people to be served and do not seek to serve more people than is required by the grant. This is not community first! They asked how parents can work to change this and discussed the need for all agencies with grant funds to be accountable to communities as well as to the funder.

- A mother who is originally from Jamaica said that paper flyers and brochures of events and businesses are posted on bulletin boards in Jamaican businesses, and this, as well as ads in print media such as *The West Indian News*, are how many people get news of resources. She suggested that effective parenting classes and education be posted in that manner.

- Several parents also talked about the effectiveness of going door-to-door and talking to people. They said that they were willing to do that.

- A father said that he had been sharing what he learned in his barbershop.

- That there is not a lot of funding for prevention and that nonprofits don't have budgets for marketing and limited budgets for outreach. Parents said that they need to do the outreach and volunteers while advocating for funding for prevention and outreach. They said that partnering with Hartford Parent University is a good way to do this outreach and awareness building.

7. Firearm Safety/Gun Violence

(Presentations by Kristin Song, parent advocate for gun safety, Hartford Communities that Care and the Bloomfield Police Department)

Parents said to have learned the following:

- There is a program that teaches children about gun safety. It used to be taught in schools and needs to be brought back. Another parent said some schools still have the program. Some schools, in which not much interest was shown, have taken the program out.

- There are many services out there; we are just not aware of them

- It is time for the programs in Hartford to get together; they need to get together with the whole community. A grandmother said that when her grandchild was killed, Saint Francis Hospital provided very good support services. She wonders why this program is in just one hospital. Saint Francis Hospital contracts with Hartford Communities that Care to provide this service, but it is not in all hospitals. Someone mentioned that this needs to go to the legislature to ensure funding to have this (Hospital Violence Intervention Program) in all emergency departments. A parent suggested we become an advocate for the program to be in all hospitals.

- There need to be more preventive measures so that kids can't get guns on the street.

- That the issue is that these guns are coming from the suburbs and into the urban community.

- You can get free gun storage safes.

8. Disability

(Presented by the Partnership for Inclusive Disaster Strategies)

Parents said to have learned the following:

- The meaning/definition of “disasters,” includes hurricanes, floods, and fires, as well as COVID-19 and other pandemics, and how people with disabilities are impacted.
- There is help from agencies like the Partnership for Inclusive Disaster Strategies.
- About the perspective of people with disabilities as powerful and independent.
- Parents learned more about autism from the father of an autistic child and about the struggles with getting needed support.
- This father, and others, learned from a parent who has a sister with a disability about services for people with disabilities from the Connecticut Department of Developmental Disabilities.
- The father learned that the school system should have started a transition plan for his son two years ago. Two mothers familiar with the process volunteered to go to the school with him to get things started.
- The father, and others, learned about Personal Care Assistance (PCA) and agencies that provide PCAs and how it works. He learned that there are options for sending his child to a group home. He shared that the school keeps telling him that his son will eventually need to go into a congregate facility. He learned there are services/agencies to help prepare his son to live independently. Everyone learned about Independence Unlimited, a Center for Independent Living in Hartford.
- Everyone learned something about people who are nonverbal and that it is possible to understand how they communicate.
- Everyone learned (more) about the discrimination people with disabilities face and how this intersects with racism and other forms of discrimination.
- Discussion about the need to change attitudes about disability, especially in the cultures represented in our group (African American, Afro-Caribbean, Puerto Rican, Dominican).
- Special education and integrating children into mainstream classrooms and that some children need individual education.

9. General Learning.

- There is inadequate planning to sustain funding for the programs that are needed.

- There needs to be a better way to communicate these services to all.
- The meaning of the term “basic needs.”

Project Continuation

Next Steps

Parents developed a comprehensive educational guide to teach parents about multiple topics related to child well-being. They named this guide *From Pain to Parenting*. It is attached to this report. In 2023, parents will implement this guide in Hartford's neighborhoods by conducting training sessions in safe and welcoming spaces.

The three-year demonstration project is the springboard for establishing ongoing planning and action to increase the years of life, health, and well-being of our children. Going into 2023, the project is being transferred from Saint Francis Hospital/Trinity Health of New England to the Institute for Community Research (ICR) as the lead agency, with two major partners: Voices of Women of Color and Hartford Parent University. The ICR will train a group of parents to design and implement their own research project. ICR will also conduct sessions to help parents understand data and advocate for data sharing with communities.

Hartford Parent University will provide ongoing training on topics identified by parents as they relate to Hartford Public Schools, especially regarding children with disabilities and children belonging to other marginalized communities.

Voices of Women of Color will provide training in community organizing and advocacy. A parent engagement group will be established in each of Hartford's 13 neighborhoods. Voices of Women of Color will help parents understand the policy and support them in speaking truth to power at municipal and state levels. The (draft) goals and objectives for 2023 are:

Goals	Objectives
1. Increase the power of parents to increase the well-being of children	● Develop a Parent/Caregiver Work Group in each of Hartford's 13 neighborhoods ● Train at least 60 parent trainers to deliver the educational guide ● Increase parent and caregiver input on policy matters affecting children and families ● Parent testimony at the municipal and state level ● 25 to complete Citizen Lobbyist Training ● 10 to testify at municipal and state levels ● 25 to communicate with elected, government, and agency officials)

2. Increase knowledge of protective factors	- Educate 150 parents and caregivers using the educational guide
3. Increase community access to and understanding of data about their children and families	- Parents to conduct research projects of their own design - Educate/review data collected by government and private researchers about Hartford's populations - Assess risk and protective factors for all parents participating in educational sessions - Research to identify best community-based practices for Hartford neighborhoods

Other Goals:

1. Implement Year One Recommendations, including at least one intervention.
2. Further development of neighborhood interventions and leadership development.
3. Parent representation on policymaking/advisory bodies.
4. Design and implement a second research project.

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