ATTACHMENT 1
Agenda Date: May 7, 2013

Sacramento County Blue Ribbon Commission




Report on Disproportionate African American Child Deaths 2013

SIERRA HEALTH FOUNDATION
An Endowment for Northern California

FIRST 5 SACRAMENTO

SACRAMENTO COUNTY

ACKNOWLEDGEMENTS

This report reflects the commitment and involvement of the members of the Blue Ribbon Commission and the valuable contributions of community members who participated in the community forums. Special appreciation to the staff of First 5 Sacramento, Sacramento County Department of Health and Human Services, and The Child Abuse Prevention Center for their support of the work of the Blue Ribbon Commission. Thank you also to the Sacramento County Child Death Review Team members, past and present, who dedicated time and resources to build the child death database. We are particularly grateful to the Sierra Health Foundation and First 5 Sacramento for funding the work of the Blue Ribbon Commission.

BOARD OF SUPERVISORS
COUNTY OF SACRAMENTO
700 H STREET, SUITE 2450 • SACRAMENTO, CA 95814

PHIL SERNA
SUPERVISOR, FIRST DISTRICT
Telephone (916) 874-5485
FAX (916) 874-7593
E-Mail: sernap@saccounty.net

April 5, 2013

Fellow Community Members,

I write to express my gratitude.

As a new County Supervisor in 2011, I was alarmed to learn that in Sacramento County African American children die at very disproportional rates compared to other kids. I was even more distressed to know that little has been done to address this chronic problem despite the fact it is something we've known about for decades.

In an effort to activate the community and engage resources to do something about it, I convened a Blue Ribbon Commission to focus on disproportionate African American child deaths. The Commission's ultimate charge is to formulate recommendations for consideration by the County Board of Supervisors so that we on the Board, with welcomed public input, can deliberate what must change to decrease all child deaths in our County.

I'm happy to report that the hard work of the Blue Ribbon Commission is coming to a close. This report represents the culmination of months of work by many enthusiastic and committed Commission members and organizations dedicated to decreasing child deaths in our community. I thank them all for their very deliberate and focused effort, as well as members of our community who've taken time to participate in the many neighborhood outreach meetings we've hosted.

Addressing the subject of disproportionate child deaths is very complicated but absolutely necessary. I remain convinced that no one person could ever hope to accomplish positive outcomes alone; it takes broad support and involves everyone from parents, to faith leaders, to physicians, to child welfare experts, and everyone in between – to make this a meaningful endeavor. Our community is extremely fortunate to have this level of commitment by so many and I remain very grateful for the work completed to date.

Respectfully,

Phil Serna
Supervisor, District 1

Sacramento County Blue Ribbon Commission Report on Disproportionate African American Child Deaths

INTRODUCTION

For two decades, known data has been reported that African American children in Sacramento County die at disproportionally high rates when compared to children of other races. In effect, a full generation of children has grown up, or has not been able to, during that period. In 2011, County Supervisor Phil Serna created the Blue Ribbon Commission on Disproportionate African American Child Deaths (Blue Ribbon Commission), and the group accepted the charge to change that history by working for the last 18 months to develop the recommendations contained in this report. The recommendations are a call to action, a challenge to us all, to stop looking the other way; to commit to all children with our collective resources, financial and otherwise; to do the right thing.

The Sacramento County Board of Supervisors directed the Blue Ribbon Commission to formulate a plan of action to reduce the rate of African American child deaths. The Blue Ribbon Commission developed a set of recommendations that will reduce African American child deaths by 10% to 20% over the next five years through targeting the most disproportionate causes of death for these children: third-party homicides, infant sleep-related deaths, child abuse and neglect homicides, and perinatal conditions.

BACKGROUND

In 2009, the Sacramento County Child Death Review Team (CDRT) marked its twentieth year investigating, analyzing and documenting the circumstances surrounding all child deaths in Sacramento County. The Sacramento County CDRT is unique in that it reviews the deaths of all children who died in Sacramento County. The CDRT finds that a thorough review of all child deaths in this county helps to identify contributing risk factors pertaining to the child's death that may not have been originally identified. This thorough analysis enables the CDRT to identify trends and opportunities to prevent future deaths. The CDRT provides an annual report and presentation to the Sacramento County Board of Supervisors of its findings and recommendations. For twenty years the CDRT has consistently found that African American children died at a rate two times higher than children of other races.

In the 2009 Annual Report the CDRT made this specific recommendation to the Sacramento County Board of Supervisors: "A**ppoint a multi-disciplinary, Sacramento County Blue Ribbon Commission to analyze data, explore causes of disproportionality in African American child death rates, and develop a coordinated strategic plan to address it."**

An analysis of the twenty years of CDRT data resulted in the Twenty Year Report that provided additional information on disproportionate child death rates. During the twenty year period from 1990 through 2009 there were a total of 3,633 Sacramento County resident child deaths, 0-17 years of age. The overall child death rate during the twenty year time period was 53.20 per 100,000 Sacramento County resident children. During the same period, a total of 816

Sacramento County Blue Ribbon Commission Report on
Disproportionate African American Child Deaths

Sacramento County African American resident children died. However, African American children consistently died at a disproportionate rate of 102.0 per 100,000 children compared to Caucasian children who died at a rate of 48.5 per 100,000 children, and Hispanic children who died at a rate of 38.3 per 100,000 children. Of the 3,633 child deaths since 1990, African American children accounted for 22% (816) of child deaths and 12% of the child population.

Table details the number, percent, and rate of child deaths by each race/ethnic group.

Table A
Child Deaths by Race/Ethnicity (n=3,633)
Sacramento County Resident Child Deaths
1990-2009

Race/Ethnicity	# of Child Deaths	% of Child Deaths	Death Rate per 100,000 Children	% Race in Child Population
African American	816	22%	102.0	12%
Asian	402	11%	44.5	13%
Caucasian	1592	44%	48.5	48%*
Hispanic	575	16%	38.3	22%
Multiracial	130	4%	48.0	4%***
Other/Unknown	118	3%	--	1%**
Total (Rate=Average)	**3,633**	**100%**	**53.2**	**100%**

*Includes other and unknown races as reported by data source
** Includes Native American and unknown race
*** Multi-racial data collection was started in 2003 by the CDRT and Public Health

During the twenty year period, all child deaths decreased annually from 237 in 1990 to 151 in 2009; likewise the rate of child deaths decreased by 53% from 84.8 to 40.0. African American child deaths over the same period decreased annually from 55 in 1990 to 30 in 2009, while the rate of African American child deaths decreased by 53% from 166.0 to 77.7. In spite of this consistent decrease, each year the proportion of African American child deaths remained higher relative to the general child population in both frequency and rate.

Figure 1 depicts the death rate for African American children in Sacramento County as compared to children of all other races, excluding African American, for the period from 1990 through 2009. Every year, on average the African American child death rate is higher than for children of all other races combined.

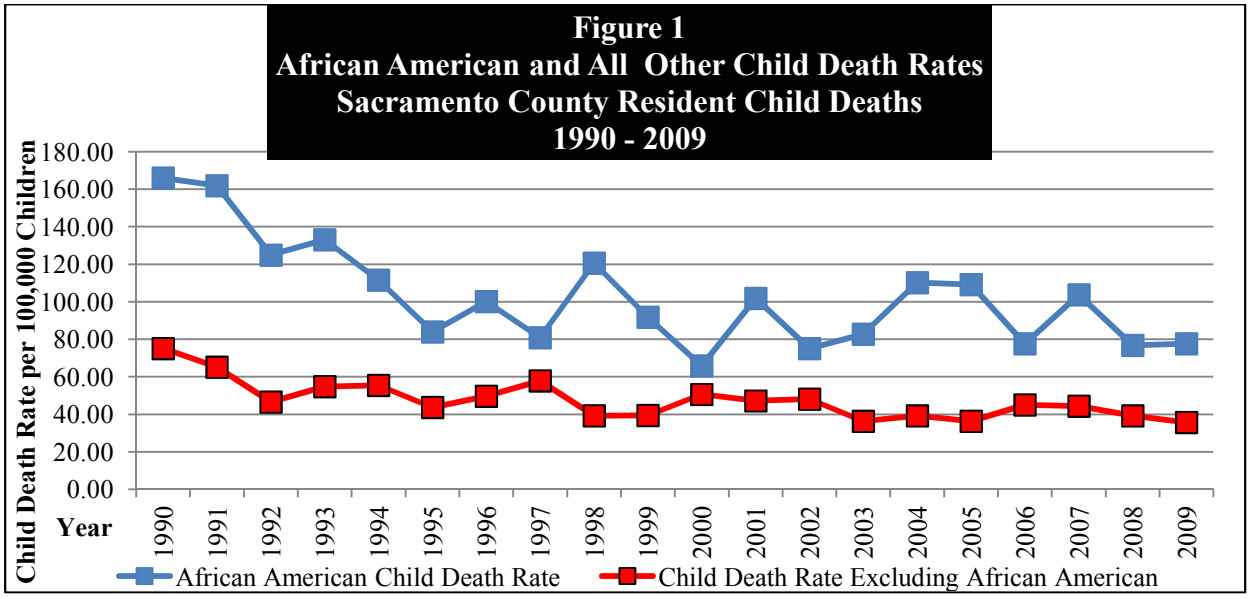


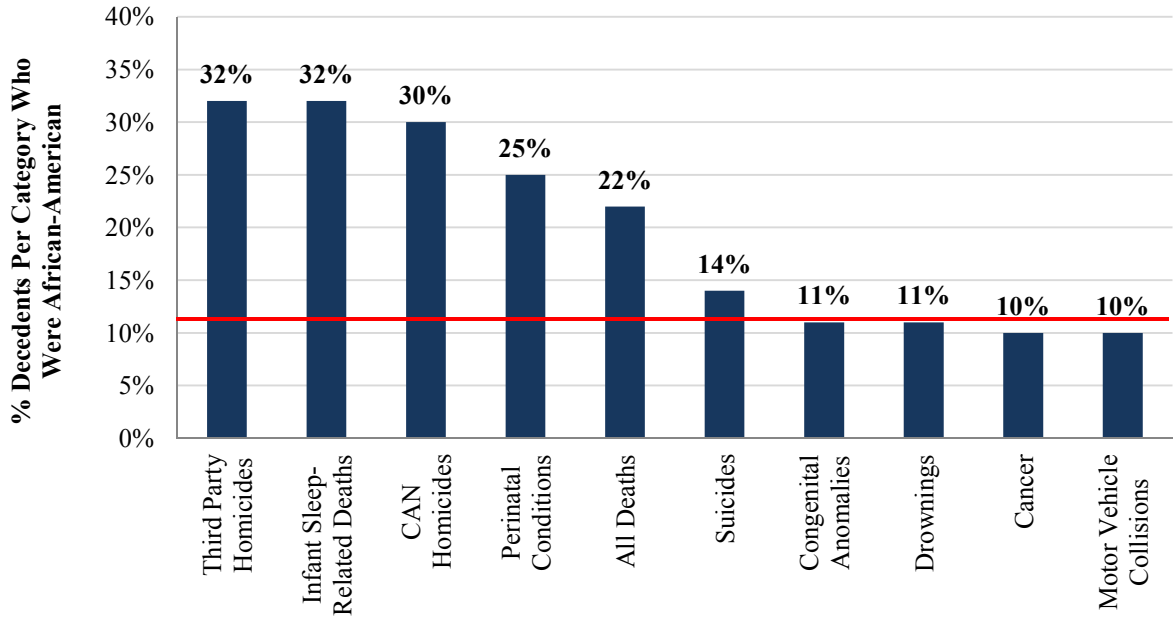
Table B provides a breakdown of all causes and manner of deaths for all children in Sacramento County from 1990 – 2009.

Table B
Sacramento County Child Deaths by Cause and Manner
1990-2009

Natural Causes		**Injury-Related Causes**	
Category of Death	**# Deaths, All Children**	**Category of Death**	**# Deaths, All Children**
Perinatal Conditions	**1041**	Motor Vehicle Collisions	272
Congenital Anomalies	581	**CAN Homicide**	**158**
Infant Sleep-Related	**420**	**Third-Party Homicide**	**138**
Other	193	Drowning	129
Cancer	192	Suicide	90
Infections	128	Other Injury	57
Respiratory	78	Suffocation	32
Undetermined - Natural	27	Burn/Fire	31
Total Natural	**2660**	Undetermined Injury	31
Undetermined, Not ISR	28	Poisoning/Overdose	7
		Total Injury-Related	**945**
TOTAL DEATHS	**3633**		

As shown in the Figure 2, African American children have a higher than average frequency of death across multiple manners of death relative to the population of African American children in Sacramento County. The red population line is present to allow easy comparison to the proportion of African American children represented in child death categories. African American children represent 12% of all children 0 through 17 years of age in the County and represent 32% (44 of 138) of all third-party child homicides; 32% (134 of 420) of all infant sleep-related deaths; 30% (48 of 158) of all child abuse and neglect homicides; and 25% (260 of 1041) of all perinatal condition deaths. Definitions and a more thorough review of each of these causes of death is provided in the Causes of Death section of this report.

Figure 2
Percent of African American Child Deaths by Category
Sacramento County Residents
1990-2009



GEOGRAPHIC DISTRIBUTION

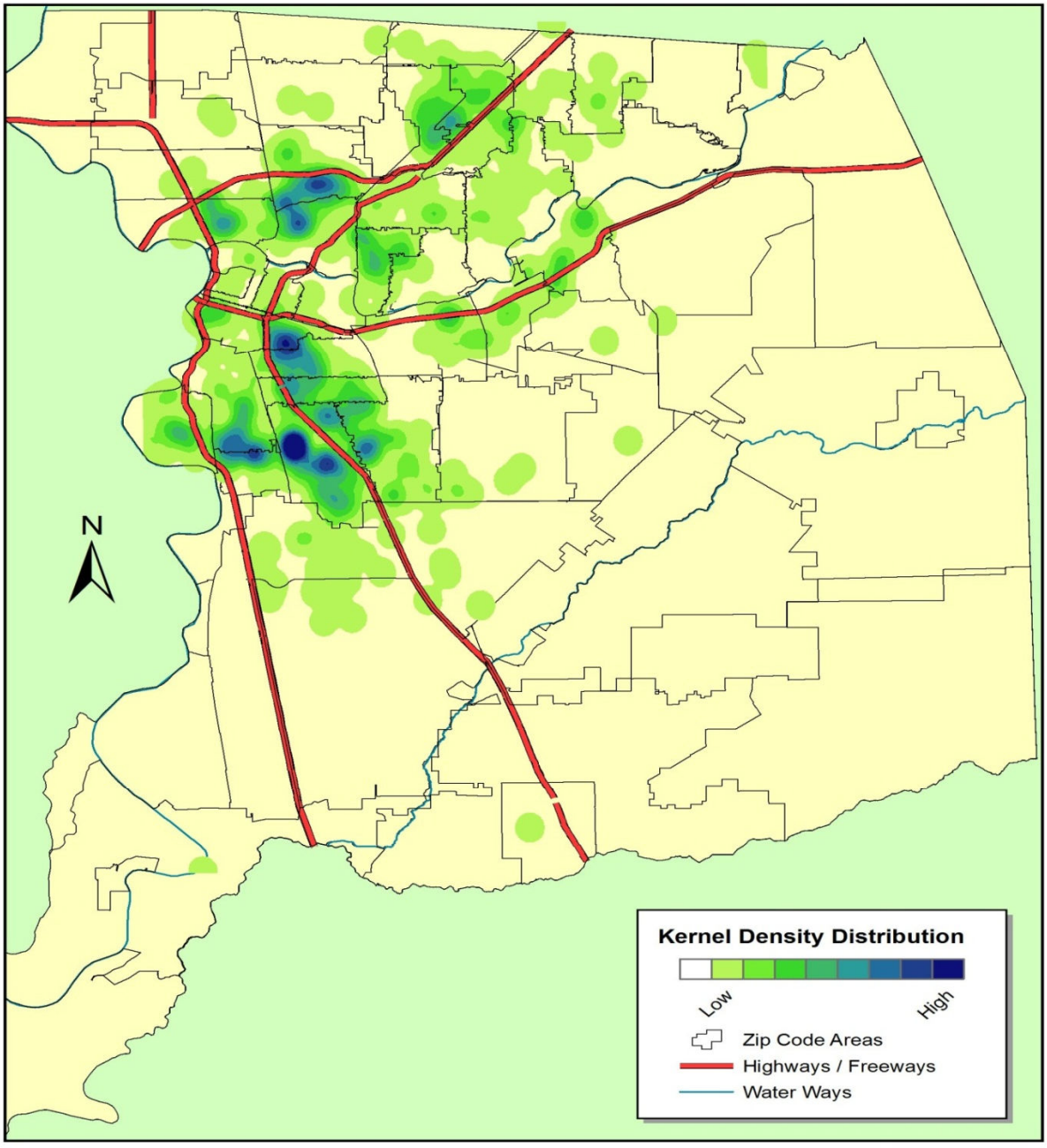
Of the 486 African American child deaths from 1990 through 2009 in the four categories of third-party homicides, infant sleep-related, child abuse and neglect homicides and perinatal conditions, 81% (392 of 486) are from six primary Sacramento County neighborhoods. These neighborhoods are the most disproportionate relative to the ratio of the child population. Table C reflects the top six neighborhoods with the largest number and percent of African American child deaths in the four categories.

Table C
Top Six Neighborhoods and Top Four Causes of Child Death with the Greatest Disproportion
Sacramento County Resident Child Deaths
1990 - 2009

	# AA Third - Party Child Homicides	# AA Infant Sleep-Related Deaths	# AA CAN Homicides	# AA Perinatal Deaths	# Total AA Deaths Among Four Categories	# Total Deaths in All Races Among Four Categories	AA Child Deaths as % of All Child Deaths Among Four Categories	AA Children as % Total Child Population In Each Neighborhood
Meadowview/ Valley Hi/ Bruceville	19	32	15	116	182	446	***41***	16
Arden-Arcade	1	6	7	19	33	95	***35***	8
North Sacramento/ Del Paso Heights	9	17	3	34	63	212	***30***	16
Oak Park	1	7	4	11	23	84	***27***	9
North Highlands	5	11	7	22	45	188	***24***	9
Fruitridge/ Stockton Blvd.	4	11	6	25	46	194	***24***	8

Map i shows the areas of highest (dark blue) and lowest (light green) incidences of African American child third-party homicides, infant sleep-related deaths, child abuse and neglect homicides, and perinatal conditions deaths between 1990 and 2009 using Kernel Density Distribution analysis. This density analysis highlights areas using color codes to identify where African American child deaths are more frequent within a radius of approximately one mile.

Map i
African American Children: Third-Party Homicides, Infant Sleep-Related Deaths, Child Abuse and Neglect Homicides, and Perinatal Conditions Deaths - Kernel Density Distribution
Sacramento County Resident Child Deaths, 1990-2009



CAUSES OF DEATH

In an attempt to develop recommendations for targeted prevention and intervention efforts, the Blue Ribbon Commission sought more information on the four causes of death that are the most disproportionate relative to the ratio of the child population: third-party homicides, infant sleep-related, child abuse and neglect homicides, and perinatal conditions. As part of the analysis, risk factors and neighborhoods were identified for purposes of focusing on recommendations with the greatest impact in reducing preventable disproportionate African American child deaths. Risk factor is the broad term used to describe characteristics, conditions, or behavior that increases the possibility of disease, injury, or death. For this report, risk factors have been aggregated from the CDRT data. Risk factors listed represent only those factors known to an agency represented on the CDRT and provided as a circumstance related to a particular child's death.

The neighborhood data is presented in two ways: 1) neighborhoods where the largest number of African American child deaths occurred for each of the four causes of death; and 2) neighborhoods where the greatest disproportion of African American children dying from each of the four causes of death occurred compared with their population in that neighborhood. The following section highlights the data regarding each of these four causes of death.

Third-Party Child Homicides: The cause of death with the highest percentage of disproportion is third-party homicide, of which 32% (44 of 138) were African American children. Third-party homicide is the killing of a child by a person with or without malice aforethought, where the perpetrator was not the primary caregiver. This can include crimes such as youth-on-youth gang violence or driving under the influence of alcohol causing a fatal accident resulting in a death of a child. Because of the nature of the crime, the perpetrator of third-party homicides is often unknown or strangers. Sixty-eight percent (95 of 139) of third-party homicides of all children and 75% (33 of 44) of third-party homicides of African American children ocurred in youth 15 to 17 years of age. Risk factors were known to be present in 60% (83 of 138) of third-party homicides of all children and 66% (29 of 44) of third-party homicides of African American children.

Information on risk factors is provided in Table D.

Table D Known Risk Factors/Family History of Third-Party Child Homicides Sacramento County Child Deaths 1990-2009				
Known Risk Factors/ Family History	**Percent of African American Child Third-Party Homicides with Known Risk Factors N = 44**		**Percent of All Child Third-Party Homicides with Known Risk Factors N=138**	
	%	#	%	#
Firearms	70%	31	69%	95
Alcohol and Other Drugs	41%	18	29%	40
Gang Involvement	30%	13	29%	40
Violent Crime[1]	23%	10	14%	20
Child Protective Services Involvement	20%	9	16%	22

Seventy-five percent (33 of 44) of third-party homicides of African American children occurred in the following neighborhoods:

- **Valley Hi/Meadowview/Bruceville** – 43% (19 of 44) of third-party homicides of African American children occurred in this neighborhood.
- **North Sacramento/Del Paso Heights** – 20% (9 of 44) of third-party homicides of African American children occurred in this neighborhood.
- **North Highlands** – 11% (5 of 44) of third-party homicides of African American children occurred in this neighborhood.

The greatest disproportion of third-party homicides of African American children as compared to third-party homicides of all children occurred in the following neighborhoods:

- **North Sacramento/Del Paso Heights** – 47% (9 of 19) of all third-party child homicides in this neighborhood were African American, while 16% of the child population in this neighborhood was African American.
- **Valley Hi/Meadowview/Bruceville** – 45% (19 of 42) of all third-party child homicides in this neighborhood were African American, while 16% of the child population in this neighborhood was African American.
- **North Highlands** – 45% (5 of 11) of all third-party child homicides in this neighborhood were African American, while 9% of the child population in this neighborhood was African American.

[1] Violent crime is a crime in which the offender uses or threatens to use violent force upon the victim. Violent crime includes but is not limited to robbery, assault, and homicide.

Infant Sleep-Related Deaths: Thirty-two percent (134 of 420) of infant sleep-related deaths were African American children. Infant sleep-related deaths are those deaths where a child less than one year old dies while sleeping. This includes Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death Syndrome (SUIDS), and deaths of an Undetermined Manner depending on circumstances surrounding the infant death.

As of 2004, the CDRT expanded unsafe infant sleep conditions data collection to capture more information on unsafe infant sleep conditions and risk factors. From 2004 through 2009, there were a total of 104 infant sleep-related deaths, of which 26% (27 of 104) were African American. Unsafe infant sleep conditions were known to be present in 89% (93 of 104) of all infant sleep-related deaths and 96% (26 of 27) of all African American infant sleep-related deaths.

Information on unsafe infant sleep conditions known to be present in all infant sleep-related deaths and those of African American infants is shown in Table E.

Table E
Known Unsafe Infant Sleep Conditions of Infant Sleep-Related Deaths
Sacramento County Child Deaths 2004-2009

Known Unsafe Infant Sleep Conditions	Percent of African American Infant Sleep-Related Deaths with Known Unsafe Sleep Conditions N = 27		Percent of All Infant Sleep-Related Deaths with Known Unsafe Sleep Conditions N=104	
	%	#	%	#
Non-infant bed	93%	25	80%	83
Co-sleeping with adults and/or siblings	70%	19	55%	57
Sleep position other than on back	30%	8	32%	33

It is important to note that the risk factors described above are not representative of all possible risk factors found in the homes of the victims, but only those risk factors associated with infant sleep-related death identified by the American Academy of Pediatrics.[2]

[2] The American Academy of Pediatrics (AAP) lists several factors related to the sleep environment as being associated with a higher risk of SIDS/SUIDS and other infant sleep-related deaths, such as being placed to sleep in a prone position, a soft sleep surface, co-sleeping, or being put to sleep with items that could cover the head or face.

In addition to the unsafe infant sleep conditions listed in Table E above, information on known risk factors is shown in Table F.

Table F
Known Risk Factors/Family History of Infant Sleep-Related Deaths
Sacramento County Child Deaths 2004-2009

Known Risk Factors / Family History	Percent of African American Infant Sleep-Related Deaths with Known Risk Factors N = 27		Percent of All Child Infant Sleep-Related Deaths with Known Risk Factors N=104	
	%	#	%	#
Alcohol and other drugs	48%	13	49%	51
Violent crime	52%	14	27%	28
Domestic violence	37%	10	20%	21

Fifty-three percent (71 of 134) of infant sleep-related deaths of African American children occurred in the following neighborhoods:

- **Valley Hi/Meadowview** – 24% (32 of 134) of infant sleep-related deaths of African American children occurred in this neighborhood.
- **North Sacramento/Del Paso Heights** – 13% (17 of 134) of infant sleep-related deaths of African American children occurred in this neighborhood.
- **North Highlands** – 8% (11 of 134) of infant sleep-related deaths of African American children occurred in this neighborhood.
- **Fruitridge/Stockton Blvd.** – 8% (11 of 134) of infant sleep-related deaths of African American children occurred in this neighborhood.

The greatest disproportion of infant sleep-related deaths of African American children as compared to all infant sleep-related deaths occurred in the following neighborhoods:

- **Valley Hi/Meadowview/Bruceville** – 46% (32 of 70) of all infant sleep-related deaths in this neighborhood were African American, while 16% of the child population in this neighborhood was African American.
- **Oak Park** – 35% (7 of 20) of all infant sleep-related deaths in this neighborhood were African American, while 9% of the child population in this neighborhood was African American.
- **Arden Arcade** – 30% (6 of 20) of all infant sleep-related deaths in this neighborhood were African American, while 8% of the child population in this neighborhood was African American.
- **North Sacramento/Del Paso Heights** – 29% (17 of 59) of all infant sleep-related deaths in this neighborhood were African American, while 16% of the child population in this neighborhood was African American.

- **North Highlands** – 28% (11 of 39) of all infant sleep-related deaths in this neighborhood were African American, while 9% of the child population in this neighborhood was African American.

Child Abuse and Neglect Homicides: Child abuse and neglect homicides are the third highest disproportionate cause of death; 30% (48 of 158) of decedents were African American children. Child abuse and neglect homicide is a homicide where the perpetrator is the primary caregiver; a death in which a child is killed, either directly, or indirectly, by his/her caregiver.

Eighty-one percent (128 of 158) of the child abuse and neglect homicides of all children and 77% (37 of 48) of the child abuse and neglect homicides of African American children occurred in children 0 to 5 years of age. Fifty-seven percent (94 of 165) of the perpetrators of all child abuse and neglect homicides and 61% (31 of 51) of the perpetrators of African American victims of child abuse and neglect homicides were the biological parents. This includes the mother or father acting alone, or both parents acting together.

Risk factors were known to be present in 65% (102 of 158) of all child abuse and neglect homicides and in 67% (32 of 48) of all child abuse and neglect homicides with African American victims. Information on known child abuse and neglect homicide risk factors is shown in Table G.

Table G
Known Risk Factors/Family History of Child Abuse and Neglect Homicides
Sacramento County Child Deaths 1990-2009

Known Risk Factors/ Family History	Percent of African American Child Abuse and Neglect Homicides with Known Risk Factors N = 48		Percent of All Child Abuse and Neglect Homicides with Known Risk Factors N=158	
	%	#	%	#
Alcohol and Other Drugs	40%	19	31%	49
Child Protective Services Involvement	29%	14	32%	51
Mental Illness	29%	14	10%	16
Violent Crime	17%	8	13%	21
Domestic Violence	17%	8	18%	28

Seventy-three percent (35 of 48) of child abuse and neglect homicides of African American children occurred in the following neighborhoods:

- **Valley Hi/Meadowview/Bruceville** – 31% (15 of 48) of child abuse and neglect homicides of African American children occurred in this neighborhood.
- **North Highlands** – 15% (7 of 48) of child abuse and neglect homicides of African American children occurred in this neighborhood.

- **Arden Arcade** – 15% (7 of 48) of child abuse and neglect homicides of African American children occurred in this neighborhood.
- **Fruitridge/Stockton Blvd.** – 13% (6 of 48) of child abuse and neglect homicides of African American children occurred in this neighborhood.

The greatest disproportion of child abuse and neglect homicides of African American children as compared to all child abuse and neglect homicides occurred in the following neighborhoods:

- **Oak Park** – 57% (4 of 7) of all child abuse and neglect homicides in this neighborhood were African American, while 9% of the child population in this neighborhood was African American.
- **Arden Arcade** – 54% (7 of 13) of all child abuse and neglect homicides in this neighborhood were African American, while 8% of the child population in this neighborhood was African American.
- **Fruitridge/Stockton Blvd.** – 38% (6 of 16) of all child abuse and neglect homicides in this neighborhood were African American, while 8% of the child population in this neighborhood was African American.

Perinatal Conditions: African American children comprised 25% (260 of 1041) of all the perinatal conditions deaths. Deaths resulting from perinatal conditions include prematurity, low birth weight, placental abruption and congenital infections. Perinatal conditions deaths span the time period from the second trimester of pregnancy through one month after birth. Perinatal conditions are often related to maternal health during pregnancy and preconception.

An analysis of the 1987 – 2007 fetal-infant death data using the Perinatal Periods of Risk Approach[3] was conducted by the Sacramento County Department of Health and Human Services, Public Health Division. The analysis showed that the rate for African American fetal-infant deaths was 4.9 per 1000 compared with 2.6 for all races, 2.4 for Caucasian, and 2.2 for Hispanic. The higher rate of deaths for African American fetal-infant deaths was related to maternal health and result in African American infants being born premature and/or with low birth weights. Related risk factors include: stress, chronic disease, smoking, substance abuse, maternal age/health, sexually transmitted diseases, multiple pregnancies such as twins or triplets, and short pregnancy intervals with frequent pregnancies.

Risk factors were known to be present in 29% (298 of 1041) of all perinatal conditions deaths and 46% (119 of 260) of perinatal conditions deaths of African American children.

Information on known perinatal conditions risk factors is shown in Table H.

[3] Perinatal Periods of Risk Approach www.CityMatCH.org

Table H Known Risk Factors/Family History of Perinatal Conditions Deaths Sacramento County Child Deaths 1990-2009				
Known Risk Factors/ Family History	**Percent of African American Perinatal Conditions Deaths with Known Risk Factors N = 260**		**Percent of All Perinatal Conditions Deaths with Known Risk Factors N=1041**	
	%	#	%	#
Alcohol and Other Drugs	26%	67	14%	147
Child Protective Services Involvement	17%	44	9%	94
Violent Crime	14%	37	7%	68
Teen mother	9%	23	5%	56
Lack of/inadequate prenatal care during pregnancy	6%	15	5%	49

Sixty-seven percent (175 of 260) of perinatal conditions deaths of African American children occurred in the following neighborhoods:

- **Valley Hi/Meadowview/Bruceville** – 45% (116 of 260) of perinatal conditions deaths of African American children occurred in this neighborhood.
- **North Sacramento/Del Paso Heights** – 13% (34 of 260) of perinatal conditions deaths of African American children occurred in this neighborhood.
- **Fruitridge/Stockton Blvd.** – 10% (25 of 260) of perinatal conditions deaths of African American children occurred in this neighborhood.

The greatest disproportion of perinatal conditions deaths of African American children as compared to all perinatal conditions deaths occurred in the following neighborhoods:

- **Valley Hi/Meadowview/Bruceville** – 40% (116 of 289) of all perinatal conditions deaths in this neighborhood were African American, while 16% of the child population in this neighborhood was African American.
- **Arden Arcade** – 33% (19 of 58) of all perinatal deaths in this neighborhood were African American, while 8% of the child population in this neighborhood was African American.
- **North Sacramento/Del Paso Heights** – 30% (34 of 115) of all perinatal deaths in this neighborhood were African American, while 16% of the child population in this neighborhood was African American.

PROCESS FOR DEVELOPMENT OF RECOMMENDATIONS

This section describes the history of the Blue Ribbon Commission and the process used to develop the recommendations. The Blue Ribbon Commission was formed in the Fall of 2011 and has met regularly since October 19, 2011. Over 40 community leaders were invited to join the Blue Ribbon Commission representing a wide array of entities including but not limited to County departments, the City of Sacramento Mayor's office, hospital systems, foundations, universities, civic groups, community based organizations, and faith-based organizations. A complete listing of participants can be found in Appendix A. Funding for the effort was provided by First 5 Sacramento and Sierra Health Foundation with in-kind support from the Sacramento County Department of Health and Human Services, First 5 Sacramento, Casey Family Programs and countless hours of support by Blue Ribbon Commissioners and their staff.

The Blue Ribbon Commission formed three Subcommittees: Practice and Strategies; Data and Research; and Community Outreach and Input. The Practice and Strategies Subcommittee merged with the Data and Research Subcommittee and together took the lead in researching the topic, looking nationwide at best and promising practices, and the development of the overarching themes and specific recommendations related to the four leading causes of disproportionate African American child death.

The Community Outreach and Input Subcommittee held three community forums in May, June and July of 2012 followed by seven focus groups held between the months of July and October of 2012. The purpose of these meetings was to solicit the community's response to the data and acquire initial input regarding solutions. A second series of three community forums were held in the first week of April 2013 to solicit input on the recommendations contained in the Blue Ribbon Commission's draft report.

After the initial information gathering phase, facilitated workgroups were convened to synthesize the information and develop the initial set of recommendations. Draft recommendations were vetted through the full Commission and then brought back to the community for comment.

The Blue Ribbon Commission conducted extensive analysis of local data, research, evaluation data, expert presentations, and outreach to the African American community including the following:

- The Child Death Review Team 2009 and Twenty Year Reports served as the foundation for data specific to Sacramento County child deaths, risk factors, geographic patterns, and trends.
- Other sources, most prominently including the Sacramento County Department of Health and Human Services and Sacramento County Children's Report Card 2011 provided corresponding data on employment, income, education, infant mortality, child abuse and neglect and other related data. Of particular note is the information on Perinatal Periods

of Risk provided by the Sacramento County Division of Public Health regarding the prevention of infant mortality.

- Casey Family Programs conducted a literature review of the pertinent research in the field and provided an overview and background materials to the Blue Ribbon Commission. A full literature review is provided in Appendix B.
- First 5 Sacramento provided background research from their analysis of programs and services in their strategic planning process.
- Expert speakers provided presentations on a wide range of topics from infant mortality to social determinants of health, including local public and private agencies from multiple disciplines. A full list of presentation topics and presenters is provided in Appendix C.
- And, critical to the integrity of the report and viability of the ongoing process, community input and guidance was elicited in multiple venues. Three community meetings were held in the neighborhoods most impacted by the disproportionate child deaths: South Sacramento, Del Paso Heights, and Oak Park. Additionally seven focus groups were held with families and clients associated with service providers in these same communities. Three additional community meetings were held in April, 2013 to seek input from the residents of the same neighborhoods regarding the draft plan and recommendations. A total of 280 community members attended and provided valuable input. A full list of dates and locations of the community meetings and focus groups is in Appendix D.

CONCEPTS

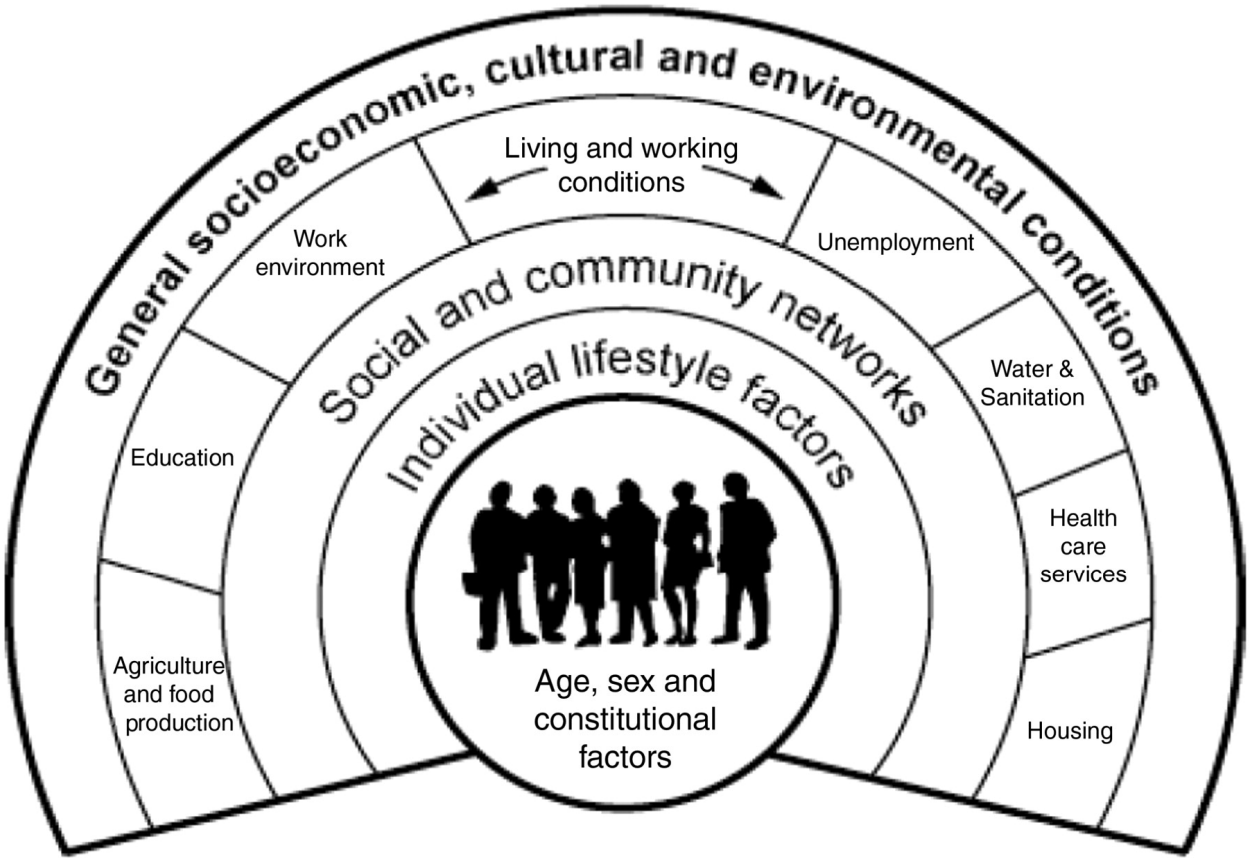
The Blue Ribbon Commission reviewed several concepts described in the following pages.

The Social Determinants of Health, recognized by the World Health Organization and Centers for Disease Control and Prevention, are the circumstances in which people are born, grow up, live, work, age and the living and working conditions. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. The relationships between these factors determine individual and population health. Interventions that target multiple determinants of health are most likely to be effective. The following diagram gives an overview of the factors and conditions that can have a direct impact on individual and community health.

African American children living in Sacramento County, as well as throughout the state and nation, experience economic, social and health disparities. As an example, when looking at Sacramento County poverty by race, the overall child poverty rate is 23.6% versus 31.7% for African American children[4].

[4] http://thenextgeneration.org/files/Prosperity_Threatened_Final.pdf and http://www.kidsdata.org/data/topic/bar/child_poverty-race20.aspx?fmt=595&loc=344

Social Determinants of Health



Risk Factors: From the CDRT data, an analysis of the number of risk factors[5] present in the four causes of child death with the greatest disproportion from 2004 from 2011 revealed that there was a higher percentage of African American children with three or more risk factors present in their death. Specifically percentages of child deaths by cause with three or more risk factors[6] are shown in Figure 3.

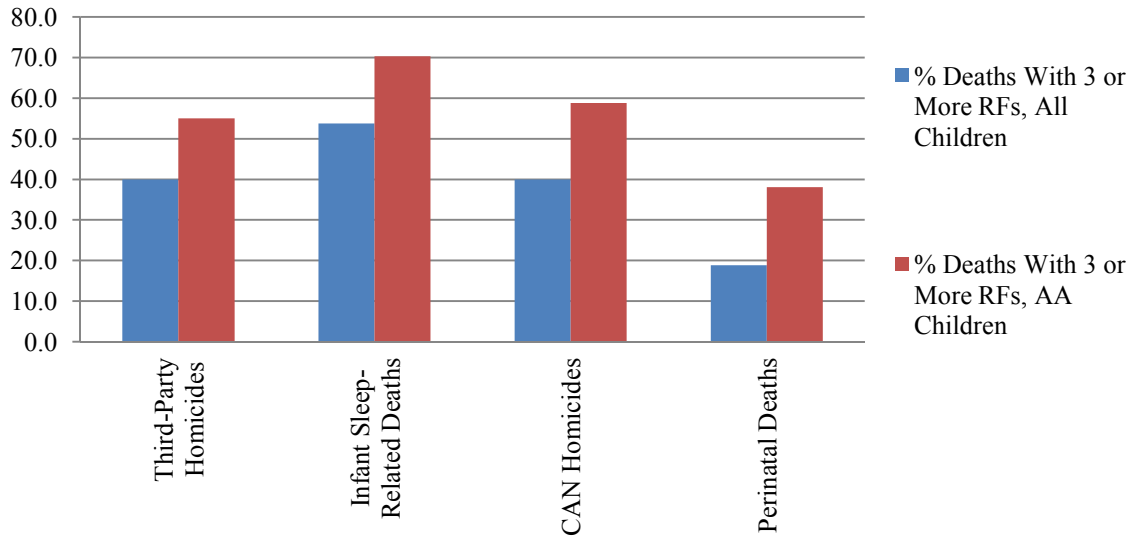
The key to understanding and preventing social problems is the relationship between the number of risk and protective factors present in a person's life. More protective factors (i.e. personal, community and other support) make it less likely a person will engage in risky behavior, use

[5] Risk factors from the CDRT, is the broad term used to describe characteristics, conditions, or behavior that increases the possibility of disease, injury, or death. Known risk factors represent only those factors known to an agency represented on the CDRT and provided as a circumstance related to a particular child's death.

[6] Source: Sacramento County Child Death Review Team

drugs, drink excessively, etc. More risk factors (e.g. childhood trauma, poverty, poor school performance, etc.) make it more likely these behaviors will occur.[7]

Figure 3
Child Decedents with Three or More Risk Factors (RF) By Cause
Sacramento County Resident Children
2004-2011



Childhood Experiences: The impact of cumulative negative experiences can have a significant impact on individuals well into adulthood. The Centers for Disease Control and Prevention-Kaiser Adverse Childhood Experiences study (1998 American Journal of Preventive Medicine) shows that childhood "toxic" stress due to adverse experiences has long lasting, and sometimes fatal impact. This study documents the link between adverse experiences (e.g. child abuse, parental substance abuse, exposure to domestic violence) and adolescent risky behaviors and health problems including substance abuse, heart disease, suicide, and others.

Community Perspective: Community members who participated in initial community meetings and focus groups were provided an overview of the data and then were asked to respond to questions related to what stood out for them in the data, what surprised them, how they felt about the information, why was this data important, and what they thought should be done to reverse this data. Their responses were documented and where possible incorporated into the draft recommendations. After developing an initial set of recommendations, the Blue Ribbon Commission held three more community meetings where community members were asked to provide input regarding the efficacy of the recommendations, identify any missing

[7] 2012 California Needs Assessment Report, Statewide Planning Unit, Performance Management Branch, California Department of Alcohol and Drug Programs, January 2013

recommendations, and give guidance on implementation. Community input on all levels has been incorporated into the plan and recommendations. The Blue Ribbon Commission recognized that the community's input and involvement was crucial and necessary. Any initiative or action moving forward will have an increased chance for success because it will more likely be culturally relevant/sensitive and supported by the community. There will be a better chance at community norm change and sustainability through regularly gathering and incorporating community input. A summary of the input provided in the community meetings is provided in Appendix E.

RECOMMENDATIONS

Reduce African American child deaths in Sacramento County by at least 10% to 20% over the next five years.

For the past 18 months, the Blue Ribbon Commission has been working to develop recommendations that will decrease the disproportion in African American child deaths in Sacramento County. While the focus of the Blue Ribbon Commission has been on child death, these deaths are sentinel events for the broader context in which the well-being of children in Sacramento County may be viewed. Deaths represent the "tip of the iceberg" in terms of severity. Non-fatal hospitalizations, injuries, violence, disease, disabilities, poverty and poor school performance occur more frequently in the community and are affected by the same conditions and risk factors. Implementing the recommendations from the Blue Ribbon Commission will reduce deaths, and also a myriad of other conditions that produce suffering and disability in children in the Sacramento County.

Child death and disparities in the African American community are complex issues; efforts to address them and to see measureable reductions will take time. To that end, the Blue Ribbon Commission has created a comprehensive set of recommendations with both short and long term goals using multiple strategies to affect change. The Blue Ribbon Commission has laid a foundation for developing interventions and policies to protect children. The implementation will take the involvement of multiple partners including policy leadership, public and private providers, schools, health care systems, faith-based organizations, law enforcement, private foundations and businesses joining with the community in making a long-term commitment to reverse the pattern of preventable child deaths. That commitment must include prioritization of funds and services and deep and honest engagement of the African American community.

This report is a call to action to reduce the incidence, rate and disproportion of African American child deaths by targeting the four causes of death which are most disproportionate: third-party homicides, infant sleep-related deaths, child abuse and neglect homicides, and perinatal conditions.

The goal set by the Blue Ribbon Commission is to reduce the unnecessary and preventable four leading causes of disproportionate African American child death by at least 10% to 20% over the next five years. While a 10% decrease would equate to 16 fewer deaths compared to the 165 African American child deaths that occurred between 2007 through 2011, a 20% decrease would reflect more substantial progress and would equate to a decrease of 32 children. Benchmarks will also be set for specific causes of death. Measures to achieve statistically significant change, change that is beyond coincidence, are as follows:

- Child abuse and neglect and third-party homicides combined[8] – 48% decrease
  - Equates to a reduction from 24 to 12 deaths over a five-year period
  - Reduces the rate per 100,000 children from 12.0 to 6.3
- Infant sleep-related deaths – 33% decrease
  - Equates to a reduction from 25 to 16 deaths over a five-year period
  - Reduces the rate per 100,000 children from 12.5 to 8.4
- Perinatal conditions death – 23% decrease
  - Equates to a reduction from 72 to 53 deaths over a five-year period
  - Reduces the rate per 100,000 children from 35.9 to 27.7

The Blue Ribbon Commission is seeking Sacramento County Board of Supervisors endorsement of overarching themes and specific recommendations related to the four leading causes of African American disproportionate death. The overarching themes were seen as common and core guiding principles across recommendations for all four causes of death. Listed below are the overarching themes for recommendations developed from Blue Ribbon Commission workgroup discussions and community input:

1. Deliberately consider the interest and well-being of all children in all short-term and long-term programs, policies and budget decisions.
2. Collaborate with other initiatives that also address the underlying social and environmental determinants of health (such as living conditions, poverty, access to resources) that impact health disparities for the African American community.
3. Prioritize and support existing and best/promising practice efforts with effective outcome data to reduce disproportionate African American child deaths.
4. Engage and empower members of the African American community to help implement, inform, and advocate for culturally appropriate strategies. These trained 'cultural brokers' will be key to numerous efforts, particularly in raising public awareness and providing direct services.

[8] Third-party homicides and child abuse and neglect homicides are combined for purposes of measurement for two reasons: 1) because the total number of deaths within each individual category is too small to attach statistical significance; and 2) both are homicides of a child just with different types of perpetrators.

5. Launch a coordinated community education and prevention campaign with messages addressing the top four causes of disproportionate child death in the African American community. The campaigns should include all forms of outreach strategies including social media, and should be delivered by trained culturally competent trusted messengers.
6. Continue the work of the Blue Ribbon Commission by establishing a steering committee to promote a coordinated public-private partnership with diverse representation to engage and empower the African American community, effectively implement recommendations, and evaluate programs to build sustainable systems with lasting impact. Recommended activities include but are not limited to: organize the infrastructure for countywide efforts; assess strengths, successes, gaps and needs in the effort; facilitate collective impact across traditional and non-traditional partners (i.e., cultural brokers); regularly solicit community input; and monitor and report progress to the Board of Supervisors and other stakeholders.
7. Improve data collection and data sharing across systems to access critical information and monitor change. Develop a system for internal and external evaluation which includes activity benchmarks and measurements.

In addition to the overarching themes, the Blue Ribbon Commission strongly endorses the adoption and implementation of a series of recommendations specific to the four leading causes of disproportionate African American child death (third-party homicides, infant sleep-related, child abuse and neglect homicides, and perinatal conditions). These recommendations are set forth under the categories described below.

- Public Awareness – Inform and engage specific populations such as parents, service providers and the general community to increase awareness and encourage changes in behaviors to reduce the risk of child death.
- Direct Services – Provide services and programs to families, including children, youth, parents and communities that have demonstrated effectiveness in reducing the four most disproportionate causes of African American child death. Leverage family contact points across all our causes of death. Decrease the risk factors associated with child death, enhance protective factors, and provide trauma informed services that counteract those risk factors.
- Policy – Institute policies that recognize children as a priority as demonstrated by services, funding, and allocation of existing resources.
- Data/Evaluation – Develop systems to further inform decision-making, coordinate data, and evaluate the education, direct services and policies recommended by the Blue Ribbon Commission.

The following matrices outline the specific recommendations in each of the four categories above that are specific to each of the four causes of disproportionate African American child death.

Third-Party Child Homicide Deaths

Finding: African American children comprised 12% of the child population and 32% of third-party child homicide deaths.[9]

Family Environments: 75% (33 of 44) of the third-party homicides of African American children occurred in youth 15 to 17 years of age. Firearms were used in 70% (31 of 44) of third-party African American child homicides. Risk factors were known to be present in 66% (29 of 44) of all third-party homicide deaths with African American child victims and include: 41% (18 of 44) family history of alcohol and other drugs, 30% (13 of 44) family history of gang involvement, 23% (10 of 44) family history of violent crime, and 20% (9 of 44) family history of Child Protective Services.[6]

Desired Outcome: Within five years, decrease the number of African American third-party and child abuse and neglect homicide deaths by at least 48%.

PUBLIC AWARENESS	DIRECT SERVICE	POLICY	DATA/EVALUATION
A. Develop and fund a community-wide culturally appropriate primary prevention campaign using all forms of social media and targeted outreach strategies delivered by trusted messengers to address third-party homicides. Elements may include: • Target youth within specific neighborhoods, apartment complexes, churches, schools, and places where youth may frequent such as hair/barber shops, light rail, malls, etc;	**A.** Emphasize school completion to increase African American youth graduation rates. **B**. Expand after-school programs to engage youth, improve graduation rates, and offer employment skills and opportunities. **C.** Fund youth employment programs in targeted communities with incentives for youth who have intersected with law enforcement. Elements	**A.** Engage the most at-risk youth throughout the planning, design, and implementation of these recommendations. **B.** Engage the school systems to: • Hire African American teachers, counselors, staff; • Offer and promote programs that engage students and parents; • Incorporate anti-violence curriculum; and • Engage higher education students, in these programs	**A.** Implement a multidisciplinary approach to share and track data. **B.** Evaluate outcomes across ethnicities to determine engagement practices and/or strategies and services that result in positive outcomes. **C.** Use data to guide funded public and private practices and strategies. **D.** Develop benchmarks for recommended activities and

[9] Source: Sacramento County Child Death Review Team Twenty Year Report 1990-2009

• Develop tools and prevention messages that are trauma informed and de-stigmatize seeking help, including gang intervention, crisis intervention, and breaking the cycle of violence; • Make resources available for all family members impacted by homicide; and • Build capacity of and provide training for service providers, faith-based sector, and community members. Training may include trauma informed care, grief counseling, psycho-social implications of death on families, and positive youth development.	may include: • Career mentoring; • Job readiness training; • Civic engagement; • Probation alternatives; and • Positive Youth Development **D.** Develop new partnerships for service delivery, to engage parents, neighbors and other trusted messengers to reinforce prevention and intervention messages. Partnerships may include: apartment complexes, PTAs/PTCs, schools, justice system, sporting events, shopping malls, Sac Regional Transit, barbershops. **E**. Promote mentoring programs within ethnically diverse communities and involve businesses, schools, and non-profits. **F**. Expand or replicate existing effective youth and violence prevention programs.	as part of their college requirements. **C.** Direct police and residents to participate in community-oriented policing programs; target law enforcement response to those most at-risk. **D.** Require affordable housing developers to underwrite social/safety programs in targeted communities. **E.** Align federal funding requests to ensure resources are directed to targeted communities.	include on-going assessment of outcomes.

Sacramento County Blue Ribbon Commission Report on
Disproportionate African American Child Deaths

Infant Sleep Related Deaths

Finding: African American infants comprised 11% of the infant population and 32% of infant sleep related deaths.[10]

Unsafe Infant Sleep Conditions/Risk Factors: Unsafe infant sleep conditions were known to be present in 96% (26 of 27) of African American infant sleep related deaths and include: 93% (25 of 27) sleeping in a non-infant bed, 70% (19 of 27) co-sleeping with adults and/or siblings, 52% (14 of 27) family history of violent crime, 48% (13 of 27) family history of alcohol and other drugs, 37% (10 of 27) family history of domestic violence, and 30% (8 of 27) sleep position other than on back. [10]

Desired Outcome: Within five years, decrease the number of African American infant sleep related deaths by at least 33%.

PUBLIC AWARENESS	DIRECT SERVICE	POLICY	DATA/EVALUATION
A. Develop and fund a coordinated community-wide campaign using all forms of social media and targeted outreach strategies delivered by trusted messengers on appropriate infant safe sleep behaviors. Elements may include: • Mobilize public/private agencies to raise public awareness, including but not limited to Child Protective Services, corrections, childcare licensing, first responders, community based service providers, faith-based sector, retail outlets, and Red-Cross;	**A**. Ensure parents leaving delivery have access to a crib, are educated on how to safely sleep their infant, and agree to comply with infant safe sleep practices. Elements may include: • Long-term commitment of resources with yearly increases as needed; and • Develop standardized assessment tool to identify risk factors. Partners to use the tool should include, but not be limited to: hospitals; Child Protective Services; Women, Infants, and Children program; home visitation services; and	**A**. Include infant safe sleep information in all high school health classes. **B.** Integrate infant safe sleep protocols into all public safety trainings to Child Protective Services, foster parents, alcohol and other drugs programs, home visitation, child care licensing, and other service providers. **C.** Adopt policies within birthing hospitals that all children born leave with infant safe sleep education and as needed, a crib to safely sleep their infant.	**A.** Evaluate outcomes across ethnicities to determine engagement practices and/or strategies and services that result in positive outcomes. **B.** Use data to guide funded strategies and include hospital, community, and faith-based practices. **C.** Develop benchmarks for recommended activities and include on-going assessment of outcomes.

[10] Source: Sacramento County Child Death Review Team Twenty Year Report 1990-2009

• Educate on infant safe sleep practices in all prenatal encounters through established effective policies and procedures within hospitals, clinics, and community based service providers; and • Utilize testimonials of parents whose infants have died.	parenting groups. **B.** Fund the coordination of an infant safe sleep campaign, in the next budget cycle, including resources to purchase cribs and education materials. **C.** Increase opportunities for infant safe sleep education through trained "cultural brokers" in existing services within neighborhoods, such as home visitation, family resource centers, clinics, and Women, Infants and Children program.		

Child Abuse and Neglect Homicide Deaths

Finding: African American children comprised 12% of the child population and 30% of child abuse and neglect homicide deaths.[11]

Family Environment: 77% (37 of 48) of the child abuse and neglect homicide deaths of African American children occurred in children 0 to 5 years of age. 61% (31 of 51) of the perpetrators of African American victims of child abuse and neglect homicide deaths were the biological parents. Risk factors were known to be present in 67% (32 of 48) of the child abuse and neglect homicide deaths with African American child victims and include: 40% (19 of 48) family history of alcohol and other drugs, 29% (14 of 48) family history of Child Protective Services, 29% (14 of 48) family history of mental illness, 17% (8 of 48) family history of violent crime, and 17% (8 of 48) family history of domestic violence. [11]

Desired Outcome: Within five years, decrease the number of African American third-party and child abuse and neglect homicide deaths by at least 48%.

PUBLIC AWARENESS	DIRECT SERVICE	POLICY	DATA/EVALUATION
A. Develop and fund a community-wide culturally appropriate primary prevention campaign using all forms of social media and targeted outreach strategies delivered by trusted messengers to address child abuse and neglect homicides. Elements may include: • Target parents within specific neighborhoods, apartment complexes, churches, schools, and places where parents may frequent such as hair/barber shops, laundromats, etc;	**A.** Emphasize evidenced-based community-based prevention programs that promote safe, stable, nurturing environments for children addressing impacts of trauma and parental stress. **B.** Incorporate trained "cultural brokers" into existing programs. Elements may include: • Develop/expand use of trained "cultural brokers" within targeted communities; and • Investigate match funding for "cultural brokers".	**A.** Recruit/train/retain a diverse workforce of services providers, including Child Protective Services, with full representation of people of color to match those served. **B.** Public/private commitment to promote avenues for safe, stable, and nurturing parenting practices. Elements may include: • Breaking the cycle of child abuse and neglect; • Recognizing the impact of trauma on children and impact of stress on parents;	**A.** Implement a multidisciplinary approach to share and track data. **B.** Evaluate outcomes across ethnicities to determine engagement practices and/or strategies and services that result in positive outcomes. **C.** Use data to guide funded public and private practices and strategies. **D.** Develop benchmarks for recommended activities and include on-going assessment

[11] Source: Sacramento County Child Death Review Team Twenty Year Report 1990-2009

• Use tools and messages that are trauma informed and normalize the need for parenting support; • Training for faith-based sector, service providers, and community members to include trauma informed care, impacts of adverse childhood experiences, parenting skills and resources; and • Identify mandated reporters and expand training to all mandated reporters providing tools and resources for identifying and reporting suspected child abuse.	**C.** Expand existing prevention /intervention services for children ages 6 and older using trained cultural brokers such as Parent Child Interaction Therapy, Crisis Nurseries, Birth & Beyond, Quality Child Care Collaborative, Early Intervention Family Drug Court, and Black Infant Health. **D.** Declare Arden Arcade and Valley Hi (neighborhoods with high rates of child abuse and neglect homicide deaths) as highest need to provide and target resources and education. **E.** Leverage all contact points with families as opportunities for prevention/intervention such as: employers, faith-based sector, elders, probation, schools, hospitals, child care. **F.** Develop a standardized hospital assessment tool, given at birth, that triages referrals based on need and tracks parent follow-up.	• Targeting interventions to families with known child abuse and neglect risk factors; and • Strengthen the community approach. **C.** Prioritize referrals of families, most at-risk based on results of the standardized screening tool, and ensure access to services that have proven to be effective in reducing child abuse and neglect. Elements may include: • Culturally competent mental health services; • Prevention and treatment services; and • Community/economic development initiatives **D.** Ensure Quality Childcare is available, affordable, and accessible.	of outcomes.

Sacramento County Blue Ribbon Commission Report on
Disproportionate African American Child Deaths

Perinatal Conditions Deaths

Finding: African American infants comprised 11% of the infant population and 25% of perinatal conditions infant deaths.[12]
Family Environment: Risk factors were known to be present in 46% (119 of 260) of African American perinatal conditions deaths and include: 26% (67 of 260) family history of alcohol and other drugs, 17% (44 of 260) family history of Child Protective Services; 14% (37 of 260) family history of violent crime; 9% (23 of 260) teen pregnancy, and 6% (15 of 260) lack of/inadequate prenatal care during pregnancy. [12]

Finding: Rate for African American feto-infant deaths is 4.9 per 1000 compared with 2.4 for Caucasian. Excess deaths are in Maternal Health.[13]
Maternal Conditions: African American babies born with very premature and/or low birth weights; smoking, substance abuse, maternal age/health, Sexually Transmitted Disease, multi-pregnancies.[13]

Desired Outcome: Within five years, decrease the number of African American perinatal conditions deaths by at least 23%.

PUBLIC AWARENESS	DIRECT SERVICE	POLICY	DATA/EVALUATION
A. Develop and fund a community-wide culturally appropriate primary prevention campaign using all forms of social media and targeted outreach strategies delivered by trusted messengers to address pre-conception health, prematurity, low birth weight, and substance abuse. Elements may include: • Targeting specific demographic of women and neighborhoods; and	**A**. Support pre-conception education, engagement, and empowerment by funding programs and building capacity of community based organizations in targeted neighborhoods that value women/girls and the role of fathers. Elements may include: • Emphasize the importance of health across the lifespan; • Direct education and messages towards fathers to help them understand and	**A**. Develop and initiate pre-conception, pre-natal, and post-natal health policy and standards that address disparities. **B**. Encourage all four health systems to coordinate community benefit funding and prioritize interventions that decrease disparities in avoidable child deaths. Elements may include: • 3-5 year funding cycles;	**A.** Improve data collection and sharing via a structure that supports standardized collection of data, a dynamic community directory, and multi-disciplinary sharing. Elements may include: • Leverage Sierra Health Foundation, The California Endowment and other community data; • Link hospital discharge data; and • Administer consumer

[12] Source: Sacramento County Child Death Review Team Twenty Year Report 1990-2009
[13] Source: Sacramento County Department of Public Health

• Specific, consistent, and coordinated messages for public and private service providers, service recipients, and community members.	value their role; • Train youth health ambassadors via youth leadership programs such as a youth summit with year-long follow-up; • Ensure access to employment and education opportunities; and • Focus programs in all schools within the 10 highest risk communities. **B.** Increase access to care by supporting the use of trained "cultural brokers". Elements may include: • Engage faith-based sector and other points of gathering; • Expand home visitation programs with effective outcomes by engaging the health care system, the faith-based and community-based organization sector; and • Provide interventions that address the social determinants of health.	• Data sharing; • Expand definition of health/wellness parameters for grant funded programs; • Incorporate these recommendations in health systems' strategic plans; and • Incorporate Affordable Care Act Prevention services summary and look for flexible funding opportunities.	pre/post care surveys. **B.** Allocate resources to allow review of all fetal and infant deaths that meet the Fetal Infant Mortality Review (FIMR) criteria. **C.** Use data to guide funded public and private practices and strategies. **D.** Develop benchmarks for recommended activities and include on-going assessment of outcomes.

Appendix A

A Complete List of Blue Ribbon Commission Participants

Name	Organization
Aguilar-Gaxiola, Sergio	University of California Davis Center for Reducing Health Disparities
Baber-Banks, Alice	NAACP Sacramento Branch
Blackwell, Dana	Casey Family Programs
Boxley, Sheila	The Child Abuse Prevention Center
Brenk, Kelly	Sutter Health Sacramento Sierra Region
Brown, Ellen	Kaiser Permanente Sacramento
Coronado, Celia	Sacramento County Board of Supervisors
Deloney, Gladys	Sacramento County Department of Human Assistance
DeLuz, David	Greater Sacramento Urban League
Doss, Charles	Family Life Center and Outreach
Edwards, Ann	Sacramento County Countywide Services Agency
Fanner, Jamie	Community Member
Fong-Somera, Linda	First 5 Sacramento Commission
Frazier, Evelyn	National Coalition of 100 Black Women
Groepper, Ron	Kaiser Permanente Sacramento
Heath, Steve	United Way California Capital Region
Heller, Sherri	Sacramento County Department of Health and Human Services
Hewitt, Chet	Sierra Health Foundation
Hubbard-Ruggles, Effie	Health Net
Johnson, Grantland	Consultant
Johnson, Kevin	City of Sacramento
Kasirye M.D., Olivia	Sacramento County Department of Health and Human Services, Public Health Division
Lewis, Edward	California Black Health Network

Lockett M.D., Cassius	Sacramento County Department of Health and Human Services, Public Health Division
Monasky, Michael	Public Health and First 5 Sacramento Advisory Committees
Moore, Leslie	University of California Davis Medical Center
Moore, Toni	First 5 Sacramento Commission
Moynihan M.D., Robert	Maternal, Child, Adolescent Health Advisory Board
Netters, Tyrone	NAACP Sacramento Branch
Oyewole, Sunday	Community Member
Pearson, Kim	Sacramento County Department of Health and Human Services, Child Protective Services Division
Petko, Wendy	Center for Community Health and Well Being
Roberson, Gina	The Child Abuse Prevention Center
Roberts, Tina	Roberts Family Development Center
Rowlett, Al	Turning Point Community Programs
Sabatoni, Madeline	Sierra Health Foundation
Saffold, Sharon	Sacramento County Department of Health and Human Services, Public Health Division, Black Infant Health Program
Serna, Phil	Sacramento County Board of Supervisors
Serre, Carol	Kaiser Permanente Sacramento
Stephanie Biegler	The Child Abuse Prevention Center
Thurston, Holly	Sacramento County Department of Health and Human Services
Tien, Christine	The California Endowment
Tucker, Kim	3Fold Communications
Wagstaff, Bruce	Sacramento County Countywide Services Agency
Whitlow, Tommie	National Council of Negro Women
Wilborn M.D., Dorothy	Kaiser Permanente Sacramento
Williams, Ephraim	St. Paul's Church
Younts, Rosemary	Mercy Hospitals of Sacramento

Appendix B

Racial Disproportionality and Disparities – Literature Review

Disproportionality – the differences in the percentage of children of a certain racial or ethnic group in the country as compared to the percentage the children of the same group in the child welfare system. For example, in 2000 African American children made up 15.1% of the children in the country but 36.6% of the children in the child welfare system.

Disparity – unequal treatment when comparing a racial or ethnic minority to a non-minority. This can be observed in many forms including decision points, treatment services, or resources. Research shows that children of color in foster care and their families are treated differently from – and often not as well as – white children and their families in the system. For example, fewer African American (AA) children received mental health services even though the identified need for this type of service may be as great (or greater) for AA children as for other racial or ethnic groups. - Robert B. Hill, Westat (2006)

Disproportionality in Child Welfare			
	Author/Sponsor	**Title**	**Issues/Main Points/Findings**
1	The Center for the Study of Social Policy	Race Equity Review: Findings from a Qualitative Analysis of Racial Disproportionality and Disparity for African American Children and Families in Michigan's Child Welfare System (2009)	Analysis of DHS protocols and policies to assess factors in Michigan's child protective system that directly contribute to racial disproportionality and disparity. Review documented gaps in child welfare work with AA families; policies and practices to assure fairness were not used as intended. Consequences of this discrepancy included: lack of prevention and intervention services, increased removals, limited family participation in case planning, and long delays in resolving issues that impacted reunification or temporary placement of children with relatives. Further findings and challenges to note were: lack of supports to prevent/divert involvement with CPS; families view services as irrelevant, difficult to access, inadequate, intrusive; labels by CPS workers negatively affect outcomes; advocacy for AA families insufficient; and inadequate mechanism to hold DHS accountable for equitable treatment and quality services. Recommendations included: Building leadership capacity, collaborations and partnerships to explore and find ways to improve quality and equity of provision and oversight of services; utilize relevant, reliable data; and translate philosophy into policies and practice.
2	Alison Bowman Laura Hofer	Racial Disproportionality in Wisconsin's Child Welfare	Three main theoretical frameworks explain the causes of disproportionality in child welfare system.

Disproportionality in Child Welfare			
	Collin O'Rourke Lindsey Read University of Wisconsin – Madison	System (2009)	1. Disproportionate Risk Factors Among Children of Color – risk factors that are more likely among families of color are the sources of disproportionality. 2. Child Welfare Services Decision-Making Model focuses on how agencies and staff may allow race to affect their decisions about the cases of children of different races. 3. Difficulties in recruiting adoptive and foster families for children of color. Examples of what some states did to address these issues: Ramsey County, MN – strengthen its process at the front end of child welfare system to provide appropriate prevention/intervention services in response to the incidents and needs of families. MN also administered initiatives, including: 1) Anti-Racism Leadership Team to train staff and managers; and 2) incorporation of full county in reducing racial disparities in child welfare using cultural consultants. Michigan - Expanded its Family to Family Program, which strives to strengthen families to prevent removal from the home, and promotes family decision making. Sioux City – IA – enacted legislations in 2003 to address overrepresentation and to improve compliance by courts with ICWA.
3	Ernestine Jones Casey- CSSP Alliance for Racial Equity in Child Welfare	Places to Watch: Promising Practice to Address Racial Disproportionality in Child Welfare Services (2008)	Actions being taken to address racial inequities in child welfare services: 1. California - San Francisco Task Force and Project involves numerous partners (such as: DHS, DPH, CDSS, Inter-City Family Resource Network, Children's Council, DA's Office, Kinship Support Network, CBOs, Faith-Based Organizations) to establish stakeholder's framework, increase cultural competence among DHS workforce, assure appropriate response to families, and through DR use the opportunity to impact disproportionality and disparity. Other states with promising practices: Connecticut, Illinois, Iowa (Sioux City), Michigan, Minnesota,

Disproportionality in Child Welfare			
			North Carolina (Guilford & Wake), Texas (San Antonio), Washington (King)
4	Marian Harris Wanda Hackett University of Washington, Tacoma	Decision Points in Child Welfare: An Action Research Model to Address Disproportionality (2007)	Focus group analysis shed light on dynamics at five key decision points: 1) reporting for abuse and neglect, 2) referral of the report for investigation, 3) reunification services, 4) placement and termination of parental rights, 5) pathways to exiting the system. Decision making appears to be the result of inter-dependent processes from multiple systems and is influenced by multiple factors. Analysis of focus group responses confirms earlier research that both attitudinal and structural factors appear to influence outcomes of decision-making.
5	US Government Accountability Office	African American Children in Foster Care Additional HHS Assistance Needed to Help States Reduce the Proportion in Care (2007)	Report analyzed major factors influencing the proportion of AA children entering and remaining in foster care, the extent that states and localities have implemented strategies that appear promising, and the ways in which key federal child welfare policies may have influenced AA representation in foster care. Results: 1) Higher rate of poverty is among several factors contributing to the higher proportion of AA children entering and remaining in foster care. 2) Most States reported using strategies to address these issues such as involving families in decisions, building community supports, and broadening the search for relatives to care for children. Recommendation that congress consider amending current law to allow subsidies for legal guardianship, which could allow states to increase number of permanent homes available for AA and other children in foster care. Also, provide states with additional TA and tools to develop strategies to address disproportionality.
6	Casey-CSSP Alliance for Racial Equity in Child Welfare	Policy Response to the GAO Audit on Disproportionality for African American Children in Foster Care (2007)	Recommendations that align with and go beyond GAO report: 1. Improve child welfare financing to promote permanency 2. Provide family strengthening and prevention services 3. Implement strength-based decision making approaches in all systems that serve children and families 4. Enhance capacity for federally funded data collection and reporting systems 5. Report on racial and ethnic disparities in

Disproportionality in Child Welfare			
			assessing state child welfare systems 6. Increase involvement of families in development and implementation of child welfare policies and practices 7. Expand cultural competence training to adequately address disproportionality and disparate outcomes
7	Susan D. Phillips, Ph.D; James Gleeson, Ph.D. University of Illinois at Chicago	What We Know Now That We Didn't Know Then About the Criminal Justice System's Involvement in Families With Whom Child Welfare Agencies Have Contact (2007)	1. Extent to which CJ system intervenes in families of children reported as victims of maltreatment 2. Specific needs and problems confronting children of incarcerated parents 3. What happens to children as their parents progress through CJ system?
8	Robert Hill, Ph.D. Westat Casey-CSSP Alliance for Racial Equity in Child Welfare	An Analysis of Racial/Ethnic Disproportionality and Disparity at the National, State, and County Levels (2007)	Study examines racial/ethnic disproportionality and disparity at national, state, and county levels, all with similar findings as they relate to AA children. Disproportionality rates rise as the child goes deeper into child welfare system from investigation through substantiation to foster care placement.
9	Robert Hill Ph.D. Westat Casey-CSSP Alliance for Racial Equity in the Child Welfare System	Synthesis of Research on Disproportionality in Child Welfare: An Update (2006)	Paper summarizes current research findings on racial disproportionality and disparities in treatment and services within the child welfare system, with a major focus on differences between blacks and whites. Most of the studies reviewed, including large national level studies and recent research, indicate that race is related to the decision making process. Race is one of the primary determinants of decisions at the stages of reporting, investigation, substantiation, placement, and exit from care. It appears that only at the last stage – when children return to foster care – that their race or ethnicity is not an issue. Compared to white children and families in the child welfare system, children of color and their families have less access to services and their outcomes are poorer. This is especially true for children of color living with relatives. Theories of causes: 1) parent and family risk factors, 2) community risk factors, 3) organizational and systemic factors.
10	Center for the Study of Social Policy	Fact Sheet 1 – Basic Facts on Disproportionate Representation of African Americans in the Foster Care System (2004) Fact Sheet 2 – State-by-State	

Disproportionality in Child Welfare			
		Statistical Profile of Racial Over-Representation in Foster Care (2004)	
11	Emily Putnam - Hornstein, Barbara Needell Center for Social Services Research, UC Berkeley	Predictors of child protective service contact between birth and age five: an examination of California's 2002 birth cohort.	The most rigorous longitudinal analysis of injury mortality following a report to CPS to date, offering strong empirical evidence that a prior, nonfatal allegation of maltreatment is an independent risk factor for injury death during the first 5 years of life in CA. Suggests that children reported for maltreatment have a truly distinctive risk profile defined by much more than poverty. A report of maltreatment is an independent signal of risk. (note: all reported children were included, even eval outs). Findings: children with a prior allegation of maltreatment died from intentional injuries at a rate that was 5.9 times greater than unreported children and died from unintentional injuries at twice the rate of unreported children. A prior allegation to CPS proved to be the strongest independent risk factor for injury mortality before the age of 5.
12	Johnson-Reid, Chance and Drake	Risk of Death Among Children Reported for Nonfatal Maltreatment (2007)	Data suggest that low-income children known to child welfare agencies are at higher risk of death than low income children and that the children most at risk may be benefited by more general targeting of high-risk families through nurse visiting, early childhood special education programs such as Parents as Teachers, etc. Also, physical abuse is not the sole cause for concern regarding risk of fatality. Neglect is a key factor.

Presentations			
	Author/Sponsor	**Title**	**Issues/Main Points/Findings**
13	Robert Hill Sania Metzger Casey Family Services	Prevention and Disparities: Reducing Disproportionality (2008)	
14	Barbara Needell, MSW, PhD UC Berkeley	Child Welfare in California: Ethnic/Racial Disproportionality and Disparity (2008)	
15	Fresno County Department of Children and Family Services	Racial Disproportionality and Disparity (2008) Information on Cultural	

Presentations			
		Broker/Paraprofessional Program	
16	Gayle Samuels (CSSP); Richard Coleman (CPS, Ramsey County) Kathy Agaton (Metis Assoc.); Dennette Derezotes (Race Matters Consortium @Westat) Jim Casey Youth Opportunities Initiative	Building on a Strong Foundation Moving to Scale: Using Data to Address Racial Equity (2006?)	

Poverty/Vulnerable Families			
	Author/Sponsor	**Title**	**Issues/Main Points/Findings**
17	Urban Institute	Children in Vulnerable Families: Facts and Figures (2006)	
18	Michelle Beadle	Children in Low Income Families (2006)	

Disproportionate Minority Contact (DMC) / Juvenile Justice			
	Author/Sponsor	**Title**	**Issues/Main Points/Findings**
19	Center for Healthy Communities	Alameda County's Juvenile Justice System Becomes a Model for Other California Communities (2009)	
20	Lois Davis M Rebecca Kilburn Dana Schultz Rand Corp Cal Endowment	Reparable Harm: Assessing and Addressing Disparities Faced By Boys and Men of Color in California	
21	Corrections Standards Authority / SIT	State Interagency Team (SIT) Disproportionality Project State Disproportionality Minority Contact (DMC) Reduction	CDSS funded 12 counties to: Review of data, communication, community engagement, family and youth engagement, and training/engagement of staff.

Disparities in Health Outcomes/Child & Infant Death Rates			
	Author/Sponsor	**Title**	**Issues/Main Points/Findings**
22	Glenn Flores and The Committee on Pediatric Research	Racial and Ethnic Disparities in Health and Health Care in Children (2010)	Conclusions: Racial and ethnic disparities in health and health care in children are extensive, pervasive, persistent, and occur across the spectrum of health and health care. Disparities were noted across the spectrum of health and health care, including mortality rates, access to care and use of services, prevention and population health, health status, adolescent health, chronic diseases… Mortality rate disparities were noted were noted for children in all 4 major us racial/ethnic groups, including

Disparities in Health Outcomes/Child & Infant Death Rates			
	Author/Sponsor	**Title**	**Issues/Main Points/Findings**
			substantially greater risks than white children of all-cause mortality. Optimal health and health care for all children will require recognition of disparities as pervasive problems.
23	Larry Cohen Anthony Iton Rachel Davis Sharon Rodriguez Prevention Institute	Local Solutions to Reduce Inequities in Health and Safety (2009)	There is a need to create a coherent, comprehensive, and sustainable health care system that is culturally and linguistically appropriate, affordable, effective, and equally accessible to all people, particularly the disenfranchised. Healthcare alone will not significantly reduce disparities as it is not the primary determinant of health. Many factors need to be changed for healthier outcomes (i.e. affordable healthcare, access to healthier foods). Healthcare institutions have critical roles to play in ensuring an emphasis on health within communities as a key part of the solution. Community Recommendations: 1. Build the capacity of community members and organizations 2. Instill health and safety considerations into land use and planning decisions 3. Improve safety and accessibility of public transportation, walking, and bicycling 4. Enhance opportunities for physical activity 5. Enhance availability of healthy products and reduce exposure to unhealthy products in underserved communities 6. Support healthy food systems and health and well-being of farmers 7. Increase housing quality, affordability, stability, and proximity to resources. 8. Improve air, water, and soil quality 9. Prevent violence using a public health framework
24	Nancy Krieger PhD	Does Racism Harm Health? An Ecosocial Perspective (2008)	How racism affects health outcomes is still at its infant stages of research. Racism is institutionalized while race/ethnicity are defined socially (not biologically). Five indirect/direct ways racism harms health: 1. Economic and social deprivation 2. Hazardous conditions 3. Socially inflicted trauma (mental, physical or sexual experienced outright or witnessed) 4. Targeted marketing of commodities (junk food, AOD) 5. Inadequate or degrading healthcare
25	Camara Phyllis Jones, MD, MPH, PhD	Levels of Racism: A Theoretic Framework and a Gardener's Tale (2000)	It is important to examine potential effects of racism in causing race-associated differences in health outcomes. There are three levels of racism: 1. Institutionalized racism is normalized by society; includes lack of services, access and opportunities 2. Personally mediated racism due to discrimination and prejudice 3. Internalized racism – put our own selves down via race

Disparities in Health Outcomes/Child & Infant Death Rates			
	Author/Sponsor	**Title**	**Issues/Main Points/Findings**
26	David Williams Chiquita Collins	US Socioeconomic and Racial Differences in Health: Patterns and Explanations (1995)	The effects of class are evident in health status and race/ethnicity remain potent predictors. Health status can be based on class, education, income, and race. Socioeconomic status (SES) differences between racial groups are largely responsible for the observed patterns of racial disparities in health status. Racism is a central determinant of the health status of oppressed racial and ethnic populations. It can restrict access to quality and quantity of health-related desirable services such as public education, health care, housing, and recreational facilities. Racial discrimination may induce psychological distress that may adversely affect physical and mental health status, and likelihood of engaging in violence/addiction.
27	Sacramento County Department of Health and Human Services	Fetal Infant Mortality Review Team 2005-2007 (Program Report 2008)	Summary Report Findings include : • Sacramento has not achieved Healthy People 2010 goal to reduce infant mortality rate to 4.5 per 1,000 live births. In 2006, the infant mortality rate was 22.2% higher. • Primary known cause of AA fetal death was maternal conditions, comprising 11.8% of fetal deaths reviewed. Primary cause of infant death was prematurity, followed by SIDs and sleep-related. • 94% of cases reviewed had identified maternal medical risk factors, 87% had fetal/infant risk factors, 81% had identified factors related to social status. Recommendations: • In a culturally sensitive manner; a) educate mothers about monitoring baby's movements and symptoms that would lead them to contact health provider, and b) educate each prenatal patient about signs of preterm labor. • Streamline MediCal enrollment procedures. • Encourage preconception and inter-conception care • Provide mothers with poor birth outcomes with follow-up care by PHN. • Create and maintain community awareness campaign that emphasizes the importance of woman's health throughout lifespan and promotes healthy lifestyles. • Review best-practices for preconception care, prenatal care, and parenting education and implement strategies to improve mental, physical, and social well-being of women of child bearing age.
28	Sacramento County Public Health Advisory Board, Perinatal Child Health Advisory Committee, Maternal Child & Adolescent Health Program	Saving Babies' Lives Community Health Plan Reducing Infant Mortality & Improving Infant Health in	Causes of Infant Mortality in Sacramento County: prematurity, birth defects, perinatal conditions, SIDs Indirect Causes: SES, violence, teen pregnancy, lack of health interventions, STDs, substance abuse, preconception care, access to health care, social support Addressing this complex issue will require a coordinated effort

Disparities in Health Outcomes/Child & Infant Death Rates			
	Author/Sponsor	**Title**	**Issues/Main Points/Findings**
		Sacramento County (2001)	from many agencies on a long-term basis. AA Disparity: • AA infant mortality rate is more than double for all groups combined. • AA infants twice as likely to be born with low birth weight or premature. • SIDs rate is more than three times the overall rate for the county.
29	MacDorman, Mathews NCHS Data Brief USDHHS, CDCP	Understanding Racial and Ethnic Disparities in US Infant Mortality Rates	In the US, different racial and ethnic groups have very different infant mortality patterns, which suggest the need for different prevention strategies. Because the percentage of preterm births for all US racial and ethnic groups is higher than in any other developed countries, all US racial and ethnic groups might benefit from prematurity prevention efforts.

Appendix C

Blue Ribbon Commission and Subcommittee Presentations

Date	Presentation	Presenter
November 7, 2012	Law Enforcement Presentation	Lt. Eklund, Sacramento City Police Department Sgt. Scott, Sacramento County Sheriff's Department
September 25, 2012	Law Enforcement Panel Presentation	Lt. Eklund, Sacramento City Police Department Sgt. Reinl & Sgt. Scott, Sacramento County Sheriff's Department
September 25, 2012	Triple P Program	Verronda Moore, First 5 Sacramento
August 8, 2012	Perinatal Periods of Risk	Dr. Kasirye, Sacramento County Public Health Officer
July 25, 2012	Sacramento County and Community Service Providers Presentation	Dr. Kasirye, Sacramento County Public Health Officer Dr. Ziegahn, Community Engagement and Research, UC Davis Medical Center Wendy Petko, Center for Community Health and Well-being Maria Morfin, Sacramento County Alcohol & Other Drug Programs Dr. Davis, Strategies for Change JoAnn Johnson, Sacramento County Mental Health Services Al Rowlett, Turning Point Community Programs Kim Pearson, Sacramento County Child Protective Services Gladys Deloney, Sacramento County Dept. of Human Assistance Natalie Woods-Andrews, Sacramento County Office of Education Lorraine Witherspoon, Sacramento County Office of Education Karlette Porter, Genesis Church
June 11, 2012	Webinar: Race, Poverty, Nativity – An Examination of Risks and Protective Factors	Barbara Needell, Ph.D., Emily Putnam-Hornstein, Ph.D., Center for Social Services Research, UC Berkeley
May 9, 2012	Social Determinants of Health	Dr. Paula Braveman Director, Center on Social Disparities in Health University of California, San Francisco
April 17, 2012	ABC's of Infant Safe Sleep, Safe Beginnings Collaborative	Stephanie Biegler, Director Child Abuse Prevention Center
April 17, 2012	Center for Community Health and Well Being	Wendy Petko, Executive Director
April 17, 2012	Child Fatalities & Child Maltreatment Literature Review	Casey Family Programs
March 28, 2012	Black Infant Health Presentation	Sharon Saffold, Sacramento County DHHS, Public Health Division
March 28, 2012	Disparity & Disproportionality Literature Review	Gina Roberson, Associate Director Child Abuse Prevention Center
March 26, 2012	The Perinatal Periods of Risk Approach	Dr. Cassius Lockett, Epidemiologist Sacramento County DHHS, Public Health Division
February 22, 2012	Bias – Impact on Decision Making	Dr. Rita Cameron, Women's Studies and Ethnic Studies California State University, Sacramento
October 19, 2011	Child Death Review Team Report 20 Year Report	Gina Roberson, Associate Director Child Abuse Prevention Center

Appendix D

Community Meetings and Focus Groups

Community input was obtained through community meetings, focus groups, and questionnaires offered to community members during community events. A total of 280 community members attended the community meetings and focus groups, and 76 completed questionnaires.

Date	Location	# of Attendees
May 15, 2012	Greater Sacramento Urban League 3725 Marysville Blvd. Sacramento, CA 95838	25
June 18, 2012	Oak Park Community Center 3425 Martin Luther King Jr. Blvd. Sacramento, CA 95817	27
July 16, 2012	Paratransit, Inc. (Auditorium) 2501 Florin Rd. Sacramento, CA 95822	33
July 24, 2012	Serna Center 5735 47th Ave. Sacramento, CA 95824	8
August 21, 2012	Women's Empowerment 1400 North C Street Sacramento, CA. 95811	40
September 26, 2012	Sacramento Food Bank & Family Services (Main Campus) 3333 3rd Ave. Sacramento, CA 95817	10
October 10, 2012	St. John's 4410 Power Inn St. Sacramento, CA 95826	13
October 18, 2012	Sacramento Food Bank & Family Services (SACA Center) 2469 Rio Linda Blvd Sacramento, CA 95815	17
October 21, 2012	Antelope Upper Room Church 6412 Watt Ave. North Highlands, 95660	26
October 23, 2012	Roberts Family Development Center 770 Darina Ave. Sacramento, CA 95815	18
April 1, 2013	Greater Sacramento Urban League 3725 Marysville Blvd. Sacramento, CA 95838	18
April 2, 2013	Paratransit, Inc. (Auditorium) 2501 Florin Rd. Sacramento, CA 95822	26
April 4, 2013	St. Paul Baptist Church 3996 14th Ave. Sacramento, CA 95820	49

Appendix E

Summary of Community Input

During the initial community meetings and focus groups, the CDRT data was provided as an overview. Community members were asked to respond through a guided discussion to the questions below, document, and share their responses. The questions asked were:

1. What did you see/hear in the presentation? What stood out for you from the data?
2. How do you feel? What surprised you about what you heard?
3. Why is this important? What can be done?

A summary of the responses is provided below:

1. What did you see/hear? What do you know?

- AA highest incidents of deaths in those categories
- neighborhoods where most deaths is where most AA live, areas underprivileged and underserved
- disparity for 20 years with no intervention
- things missing - high poverty areas, mother's health, life skills to live successfully
- Sacramento county overall death rate higher than CA
- AA child disproportionality in other areas: poverty, education, child welfare, juvenile justice (children's report card)
- lack of prenatal care
- overlay of substance abuse
- mother's age?
- degree of issues shocking to see written
- surprise at rate of AA suicide
- most child deaths in children under 5
- 1/3 of all AA child deaths are homicides
- race genocide - worried
- not new data
- third party homicide - surprising
- infant sleep related deaths surprising

2. How do you feel about the data? What surprised you about the data?

- range of emotions: sad, frustrated, anger, outraged, confused, hopeless, shocked, hopeful, disappointed, offended
- not doing enough to address this
- still dealing with same issues
- not surprised - live with it every day
- why is the community not getting the message
- educate and organize affected communities
- discussion is two dimensional

- needs to be addressed with evidence based practices
- concerned that no programs have been established to reduce numbers
- community input not strong enough on county boards
- unmet community needs
- not being heard or taken seriously
- lack of services
- lack of role models that mirror population
- missed opportunities
- disconnect of resources among agencies that touch community (collaboration)
- policies must match what's being done for this effort
- would help to have media talk about this to help put issues up front
- need more education of parents, community
- no measurment of success
- no accountability
- remove punitive outcomes to get help
- how are the children being missed with such high contact with social services
- surprised by number of sleep related

3. What can be done?

- more funding for programs that work (home visitation, after school, prenatal/pregnancy prevention
- everyone in the community needs to be engaged, grass roots, involved in developing priorities and align with resource allocation
- education
- parenting skills
- break inter-generation cycle
- engage church/faith community
- comprehensive care/public health priority
- address poverty
- address racism
- reduce chronic stress
- address substance abuse
- address violence/domestic violence
- highlight shared value/normalize/affects everyone

During the second set of community meetings, the draft report and recommendations were presented. Community members were asked to respond through a guided discussion to the questions below, document, and share their responses. The questions asked were:

1. How do you feel the recommendations will help reduce disproportionate African American child deaths?
2. How do you feel the community will embrace the recommendations?
3. What is missing?

1. How do you feel the recommendations will help reduce disproportionate African American child deaths?

- Remove labels – instead of "you need to see a therapist," say "want to talk"
- Sports therapy – mask message with a more palatable term or activity of interest
- Collaboration with non-traditional partnerships – i.e. black physicians forum – Sac Cultural Health & EW &C Exceptional Women of Color
- Childcare facilities – affordable available
- Good neighbor childcare centers
- Church Involvement – discussion & mentoring, outreach and services
- Families and schools together program 8 – 10 weeks
- Nurse Family Partnership – support home visitation programs
- Good Parts – are education & policy and if we evaluate the issue of next steps
- Some positives but we're not addressing root causes: having more education & African Americans to provide the services & create policies. Ensure information is in barber shops or other areas where African Americans congregate
- Media is good but has to be effective for the African American community
- Media by itself is not enough – pair with other activities/strategies like education
- Good Framework – add meat & details to recommendations so they can have a better picture of plans and can comment on what works and what doesn't work
- Roles of fathers – often devalue fathers as part of a child's life – fathers are instrumental; Messages directed at fathers to help them understand their role
- Leverage ACA resources to make this a reality & to make sure youth get information on how to access resources through ACA
- Excellent but at a micro level vs-macro level it is subject to economy
- Larger job opportunities/vocational job training program to develop workforce & have opportunities for parents to be employed & decrease stress
- Clarify Child Protective Services and Service Providers – for workforce & education
- Ensure there are resources available and a guide including childcare, medical, schools
- Stressed parents need education and skills to learn how to cope; lets teach this
- People lack resources – direct services should supersede education
- Funding for cribs is good
- Good but we need more

2. How do you feel the community will embrace these recommendations?

- When engaging public about parks, restrooms include law enforcement and neighbors
- People tend to feel overwhelmed by subject – will need to feel empowered not lectured at – safe places to open up
- Suspicions, fear no sustainability
- Messaging and Mentoring - "Tips" around safety issues and awareness…
- African Americans need to train the community. Assign African American advocates to help oversee programs and direct services
- Community more receptive to information from people from churches, elders

- Would like a Request For Proposal process to include smaller Community Based Organizations to amplify community assets that are already there and highlight what's missing
- May be met with some resistance because of habits/cultural traditions
- Need to address those who are experienced mothers with women who are their age to help with the information
- Address social determinants of health; if community made a part, will be accepted
- Tone of messages should be positive – empowering not blaming or negative messages; provide examples of women from the community that have had success
- Cultural sensitivity is critical. Must have right messenger to be received
- They need to see commitment and sustainability
- Resources are not the enemy
- Child Protective Services – more community forums and explanations on how they operate
- African American community hesitant – been taken advantage of – racism a factor – if it is presented by the right person with no judgment in the right way; grandmas, elders
- Important to identify those people – need relationship first and build trust

3. What is missing?

- Include disability and age, sexual orientation, gender (reflect audience specifically)
- Incentives for participants (not just volunteers)
- Interventions should be "trauma informed" (Centers on healing/less clinical/more holistic) by creating peace in the families as well as communities
- Utilizing short-succinct messages via social media, parenting magazines, Public Service Announcements; including statistics, use young ambassadors to send out messages in language they will understand/relate to, emphasize preventable
- Educate target population about better world around them
- Need focus groups with people we are trying to reach – create buy in for participants
- Marketing with baby stores i.e. Toys R us, Walmart, Target, etc.
- Outreach to grandparent networks
- Red Cross "Babysitting Safety Class/Programs"
- Community Resource Centers, African American opportunities for kids
- The ability for African Americans to sit on boards to elect teachers & principals
- Organize black community to promote and receive more culturally competent services/monies for trainings in public schools and accountability for social services
- Require more African Americans to have access to decision making and promote equity within service provider community
- More higher education support pushing African American kids/teens to do more (graduate high school, etc)
- Have African Americans in entrepreneurial opportunities – more funding pushed into African American's hands & have African Americans have more control
- Mental Health education in schools for African American children

- More detail on the hospital assessment tool – who will develop and/or administer tool? Would this tool stigmatize people & make them not use resources; Should the hospital assessment be a home assessment?
- Ensure cultural brokers are trained, apply to all agencies providing direct service.
- Look at risk factors such as a gun in the home
- Provide information and education without condemnation
- Need to address those mothers who have lost their children
- Education about infant safe sleep practices; ensure consisting with hospital messages and avoid inconsistencies, especially while encouraging breast feeding, preconception, and appropriate expectations
- Revisit Black Infant Health and Birthing Project and New Beginnings program – look at these programs. Did a decrease in their funding lead to a resurgence in rates of disproportionate deaths? Did this have a direct impact on families?
- Educate youth on preconception, subsequent births, and health in life span
- Policy – more affordable housing - lack of housing impacts safety for moms and babies – we need to increase access to housing
- Integrate & connect message to employment opportunities
- Mapping of available resources in the community and publicize it
- Must get fellow African American leaders and community members to be invested
- Address entire family as a whole and be sure to include extended family
- Mentoring for single parents in their home
- Education/Workshops about empowering parents – giving parents back their power
- Year round job programs for youth
- Reintegrate youth from juvenile system back into society
- Utilize youth interns from college campuses
- Preschool initiative and affordable childcare for kids 0 – 5 years old
- Other public entities – courts, JJDP, Adult Criminal Justice System, Law Enforcement – Training and reporting systems to catch quicker; Link Child Protective Services and the Courts
- Continuous training and support to families that is engaging and supportive to families
- After-school programs providers more culturally diverse – match monies and train students to work with parents
- Identify and expand mandated reporter trainings to all mandated reporters
- Mandatory training – accountability that mandated reporters have been trained
- Needs to start before baby is born: pre-parenting/education –prevention (pre-conception) i.e. anti-smoking/cigarette campaign
- Mentors/support for the children – help them cope and monies for supportive services
- Policy 1B: tobacco should also be listed (2nd hand smoke linked to SIDs)
- Cultural factors – breastfeeding is easier if the baby is near
- Provide alternatives that are low/no cost i.e. using a drawer, Pack N Play, baby divider prevents roll over deaths
- Teens have some caregiving responsibilities
- Impact of cumulative racism on prematurity
- Impacts all African American women Countywide – not just low income

- More buy-in from men/fathers with this issue; Father's role in the reproductive process – certificates and paperwork to fathers should be offered; father workshops
- Funding for transportation for young girls to be educated on their pregnancy
- Policy on fetal/infant child review