

CHILD FATALITY AND NEAR FATALITY REVIEW BOARD ANNUAL REPORT

NEW JERSEY | ISSUED 2018

Helping put the pieces together...

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INTRODUCTION

The **New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA)**, adopted on July 31, 1997, established the statewide **Child Fatality and Near Fatality Review Board (CFNFRB, N.J.S.A. 9:6-8.88)**. The purpose of the CFNFRB is to ensure a comprehensive case review of child fatalities and near fatalities in order to identify and determine their cause, their relationship to governmental support systems, and methods of prevention. Pursuant to **N.J.S.A. 9:6-8.91**, the CFNFRB established local community-based teams to assist in the review of child fatalities in New Jersey.

These regional multi-disciplinary teams are comprised of human services professionals from nonprofit and state organizations, as well as physicians, prosecutors, law enforcement officers, pathologists, social workers, child advocates, and educators. There are three community-based teams to represent different regions of the state; two statewide subcommittees that address specific types of fatalities, Sudden Unexplained Infant Deaths (SUID) and Suicide; and a sixth team comprised of the State Board, which reviews fatalities/near fatalities of children involved with the New Jersey Division of Child Protection and Permanency (CP&P) either at the time of the incident or within 12 months prior to the incident.

The State Board invites the CP&P staff, including front-line workers, to our monthly meeting to gather more information about the case, and to fully understand CP&P's involvement and their experience working with the family. These reviews allow CP&P staff to identify challenges and barriers they faced while working with families and how those challenges may have impacted the ability to prevent the fatality/near fatality. The Board's role is not to cast blame, rather identify ways to improve the responses of New Jersey's systems to prevent such incidents from happening to other children. Our goal is to identify ways to make improvements to the systems, and then suggest recommendations to those systems to address any barriers or challenges that exist. We look for patterns, emerging trends, or problems that repeat over time. These systems touch upon a variety of disciplinary fields, including physical health, mental health, substance use, law enforcement, and education.

This year we will not be making recommendations to specific agencies in part because we feel that preventing child fatalities/near fatalities is the responsibility of everyone who encounters a child in New Jersey. When we analyzed the recommendations that came out of each review, we noted that enhancing communications or "breaking down silos" was a primary concern. We recognize and commend recent collaborations between departments of the New Jersey state government as evidenced by their commissioners frequently coming together at various events, in effect, presenting a united front with which to address the most pressing public health and social issues impacting the children; we applaud this and urge its continuation moving forward. Additionally, we are aware that the Department of Children and Families has been tasked with creating a five-year plan to prevent child fatalities; we strongly recommend that this plan embody a spirit of collaboration and be adopted and/or recognized by all concerned parties. We will also be seeking assistance from the current administration to forward this year's recommendations to the appropriate state officials, for their consideration, as deemed appropriate.

Thank you for taking the time to review this report: in many ways, we feel that the review process and this, the resulting report, is the last opportunity for these children's voices to be heard. We hope that all stakeholders will attend to this call for increased communication and collaboration. Most importantly, we hope that New Jersey can learn from the deaths of these children to successfully prevent future tragedies.

Sincerely,

Kathryn McCans, M.D., F.A.A.P.
Chairwoman

SELECTING AND REVIEWING CASES

The Review Process

The CFNFRB is notified of child deaths by several sources, including the State Central Registry (SCR), the Office of the State Medical Examiner, Law Enforcement, and upon request, the Department of Health. Once a case is identified for review, liaison staff is responsible for obtaining all relevant records including, but not limited to, autopsy, death scene investigation, law enforcement, educational, mental health, medical, and social service records. The CFNFRB has the authority to subpoena and secure the required materials as necessary.

All relevant documentation is posted in a secure on-line library approximately two (2) weeks before a scheduled meeting for members to review in preparation for discussion.

Some of the possible actions following each case review include: policy and practice changes in particular fields, strengthening interagency collaboration, staff training, public outreach and education, or changes to state law. Lessons learned from these tragedies lead to stronger prevention efforts that help protect children, keeping them safe and healthy.

STAFF:

Lisa Kay Hartmann, State Coordinator,
Lauren Woods, Amanda Craig, and
Nicholas Pecht, DCF Liaisons to CFNFRB

Cases are selected for review based on NJ State law. Cases are reviewable when the cause of death is:

- Undetermined
- Substance abuse¹ may have been a contributing factor
- Homicide due to child abuse or neglect
- Child abuse or neglect may have been a contributing factor
- Malnutrition, dehydration, medical neglect or failure to thrive
- Sexual Abuse
- Head trauma, fractures, or blunt force trauma without obvious innocent reason, such as auto accidents
- Suffocation or asphyxia
- Burns without obvious innocent reason, such as auto accident or house fire
- Suicide
- Children whose families were under the supervision of the Division of Child Protection and Permanency (CP&P) at the time of the fatal or near fatal incident or within twelve (12) months immediately preceding the fatal or near fatal incident.
- Drowning
- Motor vehicle accidents in which the child:
 - Had a positive toxicology screen
 - Was under the supervision of CP&P
- All Sudden Unexpected Infant Deaths (SUID); which include children whose cause of death is Sudden Infant Death Syndrome (SIDS).

¹includes substance use

MEMBERS

The CFNFRB is comprised of six teams: the State CFNFR Board, the Northern, Central and Southern Community-Based Teams, the Sudden Unexpected Infant Death (SUID) Subcommittee, and the Suicide Subcommittee. The State Board reviews only those cases in which CP&P was involved at the time of the fatality/near fatality or within the twelve months prior. The SUID Subcommittee reviews all deaths in children under 1 year old whose cause/manner was SUID, Sudden Infant Death Syndrome (SIDS), undetermined, or were in some way sleep-related. The Suicide Subcommittee reviews all deaths due to suicide, and the regional teams review all other cases, including homicides, substance use-related fatalities and drownings.

The State CFNFR Board Members:

- **Chair: Kathryn McCans, M.D., F.A.A.P.**, St. Christopher's Hospital for Children
- Dr. Shereef Elnahal, Commissioner, Department of Health, Designee: **Lakota Kruse, M.D., M.P.H.**
- Christine Norbut Beyer, M.S.W., Commissioner, Department of Children and Families, Designee: **Aubrey C. Powers, Assistant Commissioner**, Office of Performance Management and Accountability.
- **Christopher Gramiccioni, Esq.**, Prosecutor, Monmouth County
- **Andrew L. Falzon, M.D.**, State Medical Examiner
- Col. Rick Fuentes, Superintendent, New Jersey State Police, Designee: **Lt. Thomas Wiczerak**
- **Daniel Yale**, New Jersey Task Force on Child Abuse and Neglect
- Christopher S. Porrino, Office of the Attorney General, Division of Law, Designee: **Lea DeGuilo, Esq.**
- **Lillian Brennan Esq.**, Deputy Public Defender, Office of the Law Guardian
- **Carmen Diaz-Petti, Assistant Commissioner**, CP&P, Department of Children and Families
- **Elayne Weitz, Psy.D.**, Licensed Clinical Psychologist

Sudden Unexpected Infant Death Subcommittee

- **Lillian Brennan, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Susan Fiorilla**, Division of Child Protection and Permanency
- **Lakota Kruse, M.D., M.P.H.**, Department of Health
- **Det. Matt Norton**, Mercer County Prosecutor's Office
- **Matthew Maguire**, Cooper Hospital
- **Carolyn Revercomb, M.D.**, Southern Regional Medical Examiner's Office
- **Nancy Mimm, M.S.N., D.N.P.**, Department of Health
- **Lenore Scott**, Early Childhood Services, Family & Community Partnerships
- **Alissa Sandler**, SIDS Center of NJ

Suicide Subcommittee

- **Andrew L. Falzon, M.D.**, State Medical Examiner
- **Michelle Scott, Ph.D., M.S.W.**, Monmouth University
- **Maureen Brogan, L.P.C., D.R.C.C.**, Traumatic Loss Coalition
- **Marisol Garces, M.S.W.**, Division of Child Protection and Permanency
- **Elizabeth Dahms, MS, R.N.-B.C.**, Department of Health
- **Det. Sgt. Michael A. Sperry**, Burlington County Prosecutor's Office
- **Iris Moore**, Division of Child Protection and Permanency
- **Ruby Goyal-Carkeek**, Children's System of Care
- **Michele Safrin**, Office of Adolescent Services

MEMBERS CONTINUED

Northern Regional Community-Based Team

(Counties: Bergen, Hudson, Morris, Essex, Passaic, Sussex, Warren)

- **Chair: Paulett Diah, M.D.**, Hackensack University Medical Center (HUMC)
- **Frederick DiCarlo, M.D.**, Bergen County Medical Examiner's Office
- **Maria Ojeda**, Division of Child Protection and Permanency
- **Joseph Papisidero, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Sandra Parente**, Division of Child Protection and Permanency
- **Albert Sanz, M.D.**, St. Joseph's Hospital
- **Lt. Javier Toro**, Hudson County Prosecutor's Office
- **Matthew Troiano**, Morris County Prosecutor's Office
- **Karen Eigen, MD, MPH**, Pediatric Emergency Department, Hackensack Meridian
- **Laura Johnson, M.S.W.**, Rutgers University, Center on Violence Against Women and Children

Central Regional Community-Based Team

(Counties: Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset, Union)

- **Chair: Dr. Gladibel Medina, M.D.**, Dorothy B. Hersh Child Protection Center
- **Lillian Brennan, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Marisol Garces**, Division of Child Protection and Permanency
- **Carol Ann Giardelli**, Director, Safe Kids New Jersey –Central Jersey Family Health Consortium
- **Det. Matthew Norton**, Mercer County Prosecutor's Office
- **Joan Pierson**, Division of Child Protection and Permanency

Southern Regional Community-Based Team

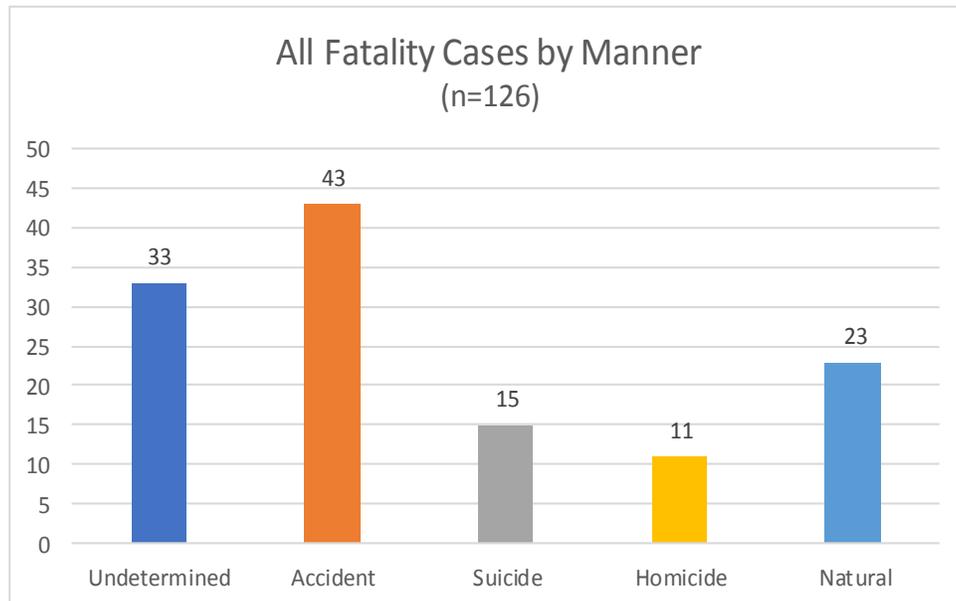
(Counties: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Salem)

- **Chair: Laura Brennan, M.D.**, Rowan University, School of Osteopathic Medicine
- **Mary Alison Albright, Esq.**, Camden County Prosecutor's Office (Retired)
- **Nanette Briggs, Esq.**, Office of the Public Defender, Office of Law Guardian
- **Ian Hood, M.D.**, Burlington County Medical Examiner's Office
- **Lt. James Kirschner**, Atlantic County Prosecutor's Office
- **Barbara May, R.N., M.P.H.**, Southern NJ Perinatal Cooperative, Inc.
- **Iris Moore**, Division of Child Protection and Permanency
- **Robert G. Moore**, Division of Child Protection and Permanency
- **Det. Frank Sabella**, Cumberland County Prosecutor's Office
- **Christine Shah, Esq.**, Camden County Prosecutor's Office
- **Det. Sgt. Michael A. Sperry**, Burlington County Prosecutor's Office
- **John Flammer, Esq.**, Atlantic County Prosecutor's Office
- **Jacqueline Forss**, Division of Child Protection and Permanency
- **Sara Plummer, Ph.D., M.S.W.**, Rutgers University, School of Social Work

STATEWIDE

All data represented herein, including all charts and graphs, unless otherwise specified, was collected during the review process of the 2016 fatalities and near fatalities and analyzed by DCF liaisons to the CFNFRB.

The Fatality and Executive Review Unit of the Department of Children and Families was notified of 318 child fatalities/near fatalities in New Jersey that occurred in calendar year 2016. Of those 318 cases, 141 met the criteria for review. Of those 141 cases reviewed, 15 were near fatalities.

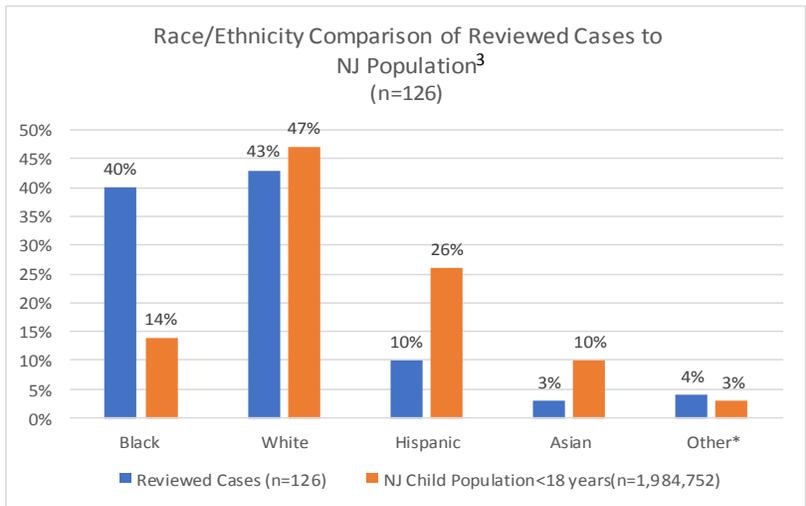


The leading cause of death in each manner of death is as follows:

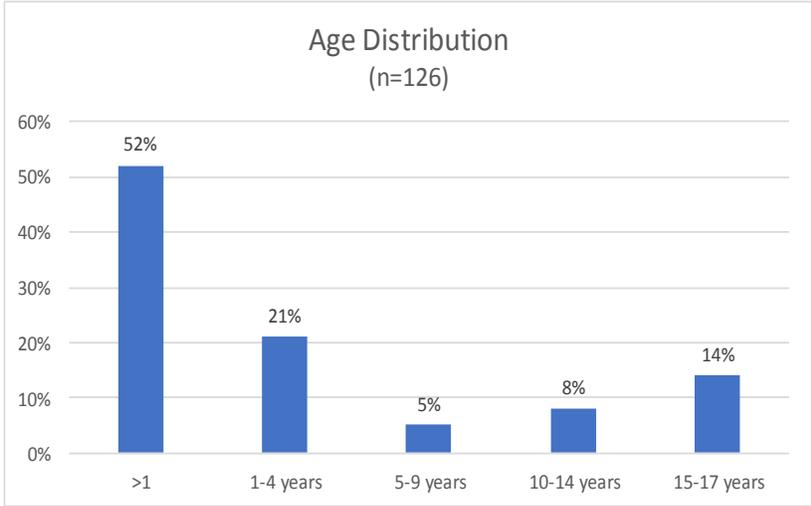
- 82% (27) of the Undetermined cases were sudden unexpected infant death (SUID)/Sleep-Related, followed by one case of electrocution and blunt impact injuries, one case of hanging, one gunshot wound and three undetermined cases.
- 37% (16) of the Accident cases were SUID/Sleep-Related and 25% (11) of the deaths were due to drowning. Other causes included six drug-related, three asphyxia, three cases of carbon monoxide poisoning, two blunt force injuries, one gunshot wound and one poisoning.
- 73% (11) of the Suicide cases were caused by hanging, followed by three cases with firearms and one from blunt force trauma.
- 55% (6) of the Homicide cases were caused by blunt force trauma, 18% (2) were caused by gunshot wounds, followed by one strangulation, one drug intoxication and one smoke inhalation.
- 83% (19) of the Natural cases were SUID/Sleep-Related² followed by three medical deaths and one undetermined.
- 40% (58) of all reviewed cases were related to SUID and/or the sleeping environment.

² Some medical examiners rule the SUIDs natural while some rule them undetermined.

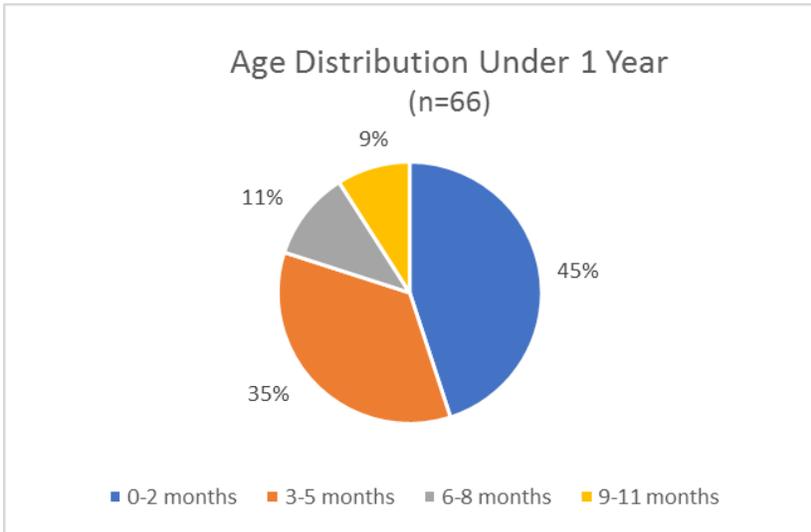
STATEWIDE CONTINUED



³Data obtained from the US Census 2016 estimates



Gender Distribution:
 59% Male
 41% Female

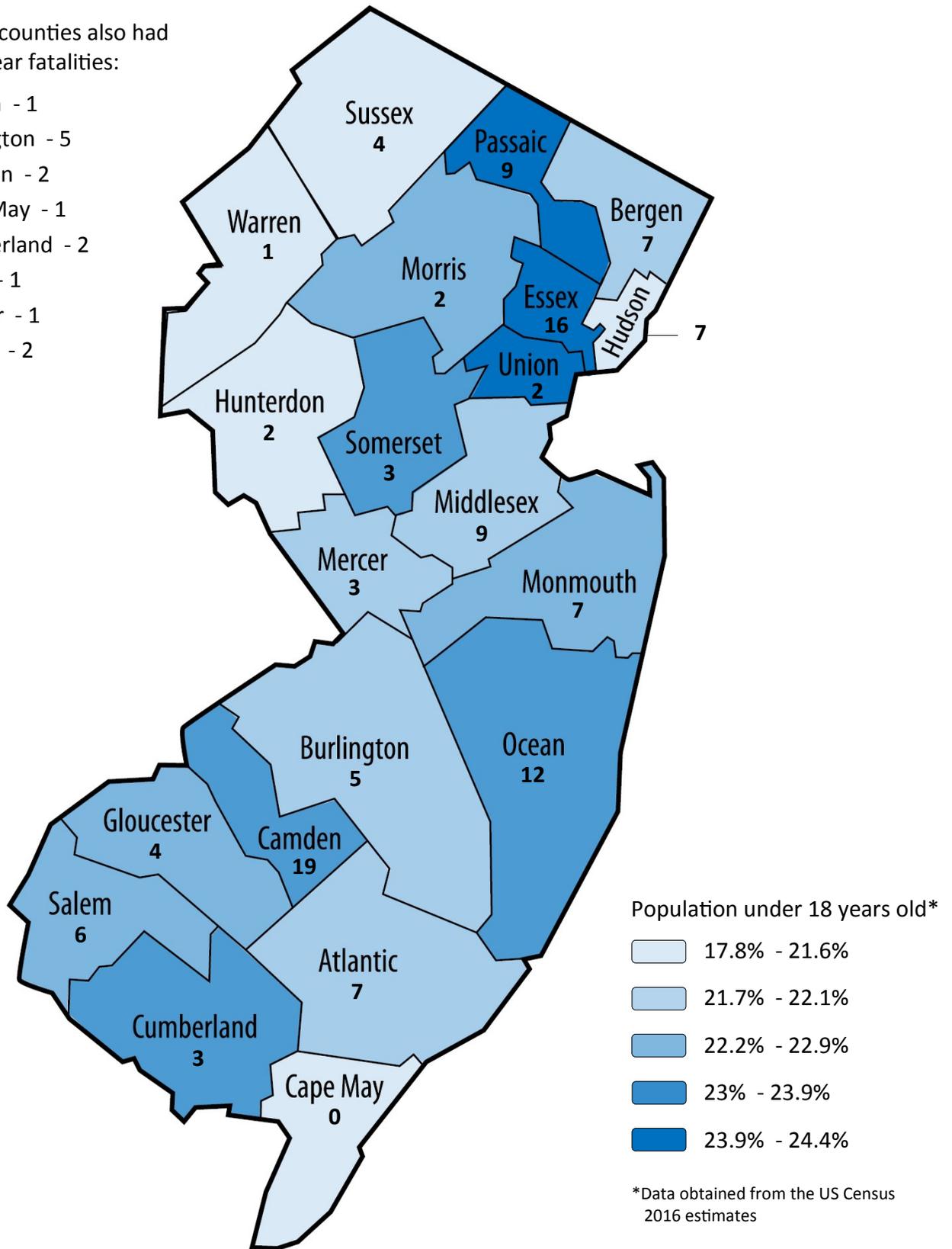


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REVIEWED 2016 FATALITIES BY COUNTY OF INCIDENT

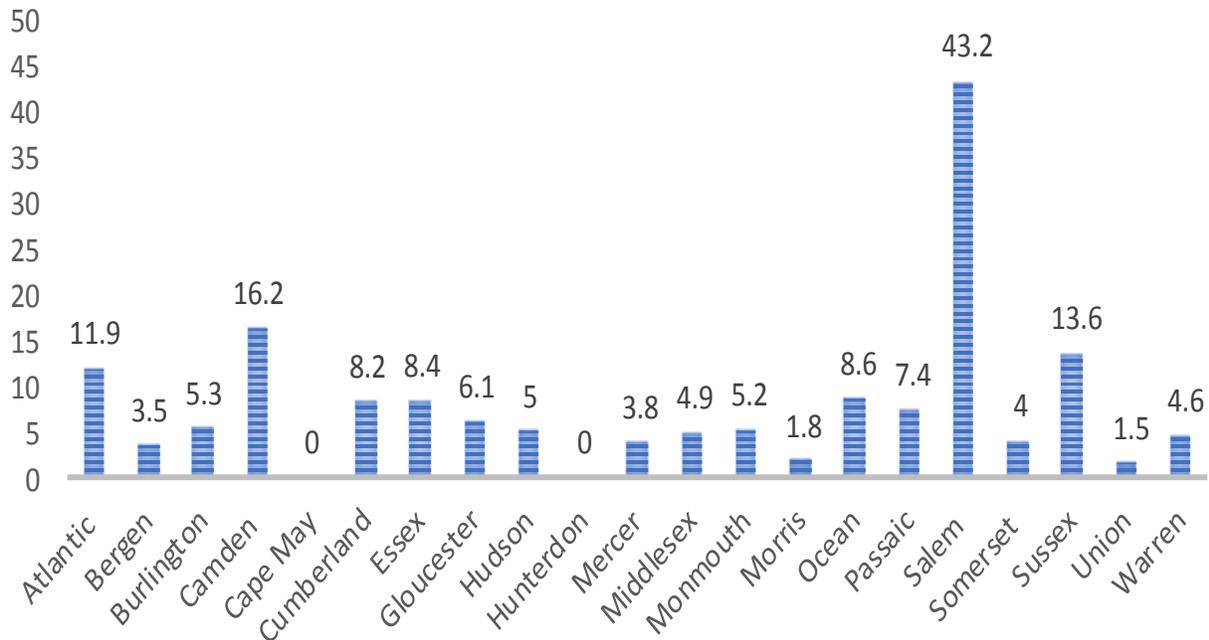
The following counties also had Reviewable near fatalities:

- Bergen - 1
- Burlington - 5
- Camden - 2
- Cape May - 1
- Cumberland - 2
- Essex - 1
- Mercer - 1
- Morris - 2



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2016 REVIEWED FATALITY RATE PER 100,000 CHILDREN



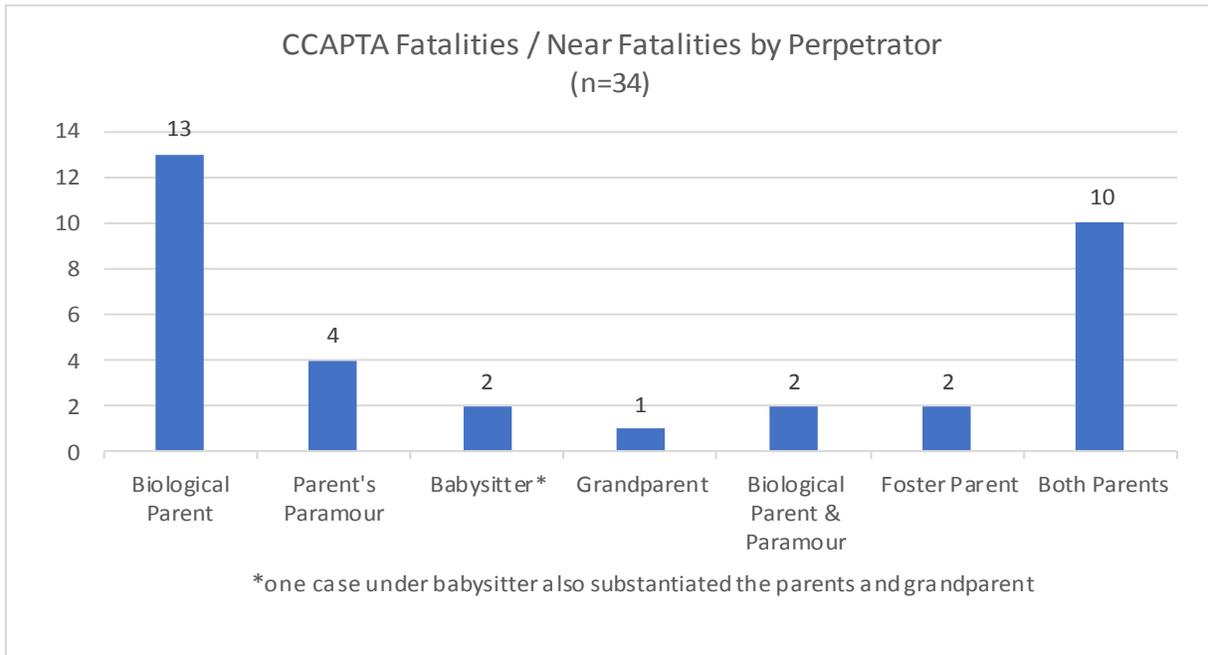
County	Accident	Homicide	Natural	Suicide	Undetermined	County Fatalities	% of NJ Fatalities	< 18 years old ⁵	Fatality Rate per 100,000 Children
Atlantic	2	1	1	1	2	7	6%	58,805	11.9
Bergen	3	0	0	3	1	7	6%	200,978	3.5
Burlington	1	1	0	2	1	5	4%	94,799	5.3
Camden	7	4	5	1	2	19	15%	117,335	16.2
Cape May	0	0	0	0	0	0	0%	16,809	0
Cumberland	1	0	1	0	1	3	2%	36,604	8.2
Essex	2	1	1	1	10	16	13%	189,666	8.4
Gloucester	2	1	1	0	0	4	3%	65,774	6.1
Hudson	2	0	1	0	4	7	6%	138,987	5
Hunterdon	0	0	0	0	0	0	0%	25,185	0
Mercer	2	0	0	1	0	3	2%	79,770	3.8
Middlesex	2	0	2	1	4	9	7%	182,482	4.9
Monmouth	3	0	1	0	3	7	6%	135,183	5.2
Morris	1	0	0	0	1	2	1.50%	108,158	1.8
Ocean	5	0	5	0	2	12	9%	139,829	8.6
Passaic	3	1	1	2	2	9	7%	122,415	7.4
Salem	2	1	3	0	0	6	5%	13,892	43.2
Somerset	0	1	0	2	0	3	2%	75,094	4
Sussex	2	0	1	1	0	4	3%	29,360	13.6
Union	2	0	0	0	0	2	1.50%	131,129	1.5
Warren	1	0	0	0	0	1	1%	21,856	4.6
State Total	43	11	23	15	33	126	100%	1,984,107	7.8

⁵Number of individuals under 18 years old obtained from US Census 2016 estimates. website: <https://www.census.gov/data.html>

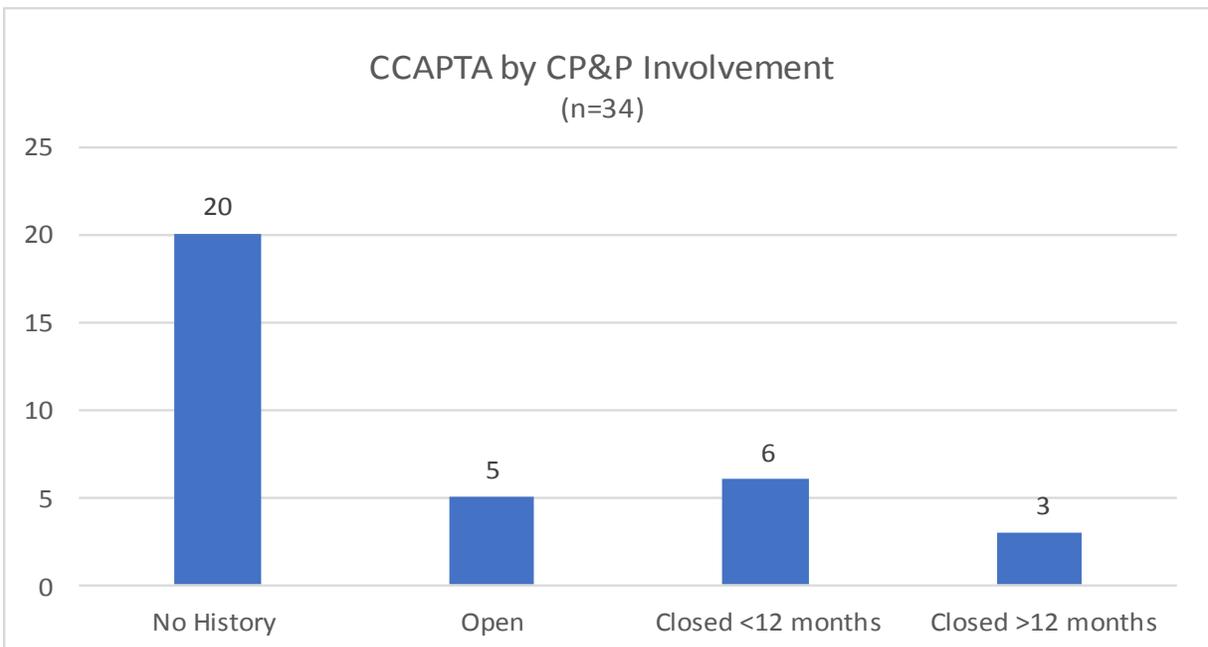
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COMPREHENSIVE CHILD ABUSE PREVENTION & TREATMENT ACT

The CFNFRB serves as one of the citizen review panels established by the Comprehensive Child Abuse Prevention and Treatment Act of 1997 (CCAPTA). A case is considered a 'CCAPTA' when a child fatality or near fatality is the result of child abuse or neglect; whether or not the family was involved with CP&P at the time of the incident.



Of the 34 incidents that constitute the 2016 CCAPTA cases, 32% (11) of those children were involved



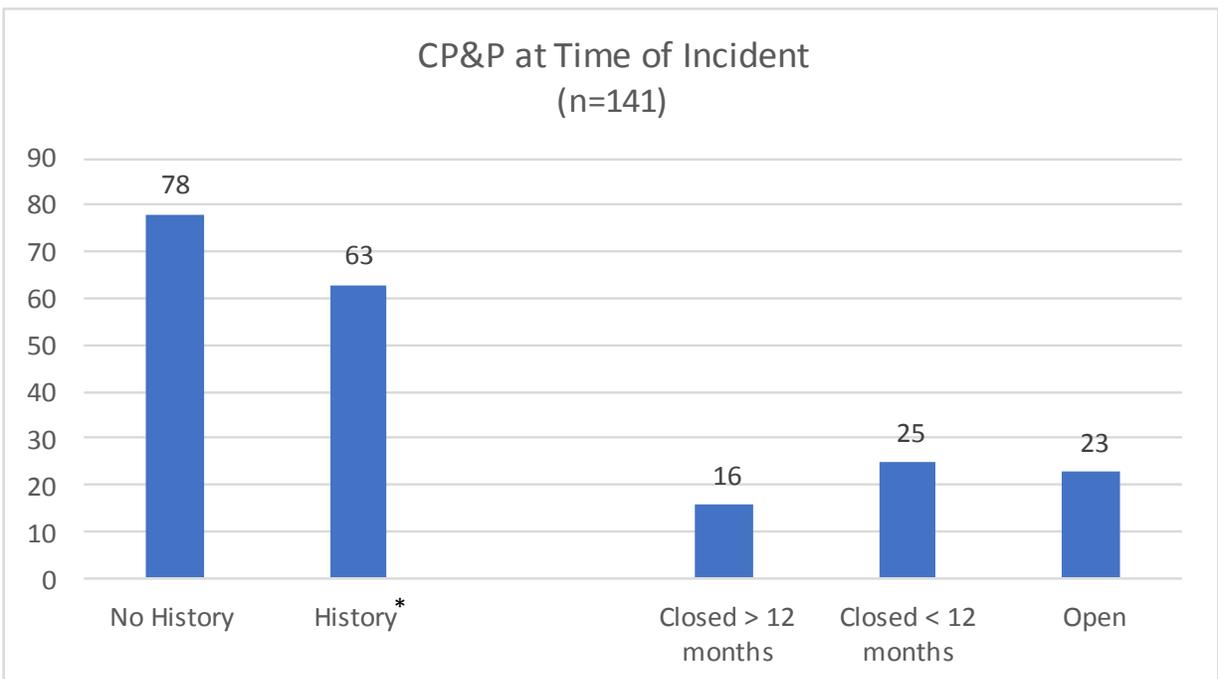
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DIVISION OF CHILD PROTECTION AND PERMANENCY

Child Protection and Permanency (CP&P) is New Jersey's child protection and child welfare agency within the New Jersey Department of Children and Families. Its mission is to ensure the safety, permanency, and well-being of children and support families. CP&P is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment. The Child Abuse Hotline (State Central Registry) receives reports of child abuse and neglect 24-hours a day, 7-days a week. Reports requiring a field response are forwarded to the CP&P Local Office who investigates.

State Central Registry (SCR):

1-877-652-2873 / 1-877-NJ-ABUSE

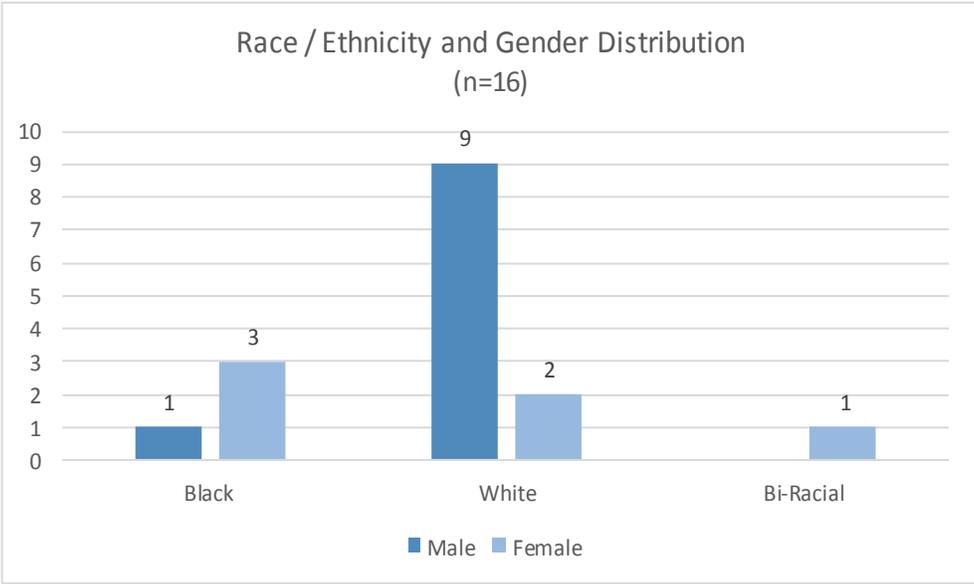


*includes all children who had ever been involved with CP&P regardless of timeframe.

- 16% (23) of the cases reviewed were open with CP&P at the time of the incident.
- Of the 141 children reviewed, 45% (63) of them had, at some point in their life, been involved with CP&P.

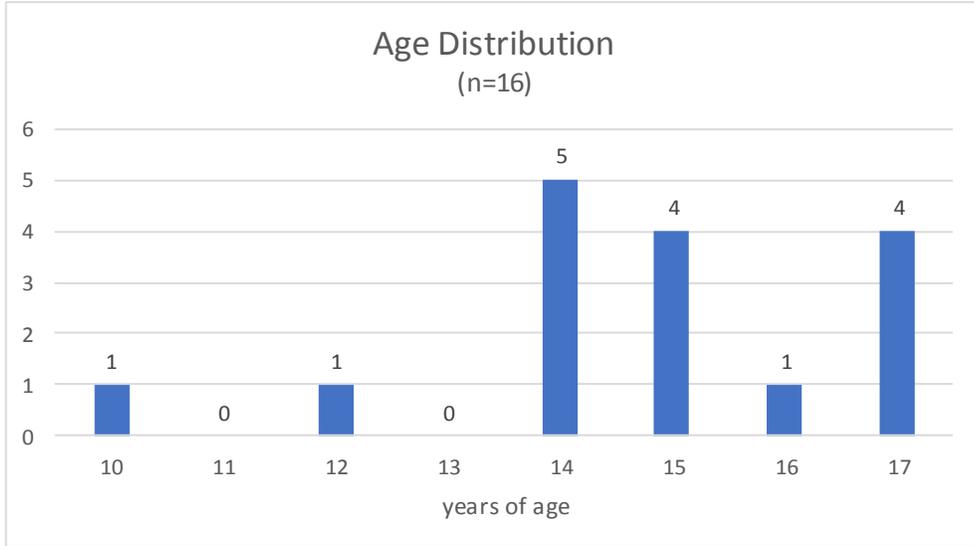
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SUICIDE



Method

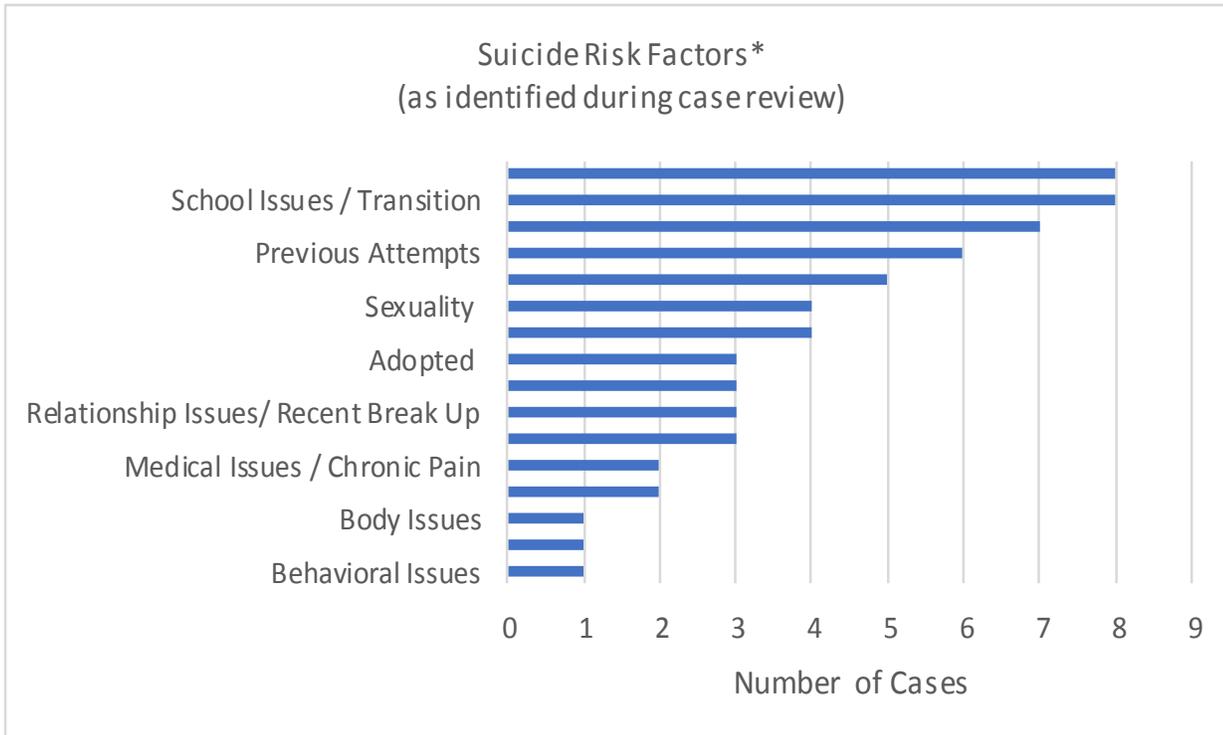
75% (12) of the suicides were completed by hanging.
 19% (3) included use of a firearm and one blunt force trauma.
 The remaining methods (5) included use of a firearm, blunt force trauma and drowning.



Suicidal Warning Signs⁶: Talking about wanting to die • Looking for a way to kill themselves • Feeling hopeless or having no reason to live • Talking about feeling trapped or in unbearable pain • Extreme mood swings or sudden changes in personality • Talking about being a burden to others • Increasing use of alcohol or drugs • Acting anxious or agitated • Behaving recklessly • Sleeping too little or too much • Withdrawing or isolating themselves • Showing rage or talking about seeking revenge

⁶Source: <https://suicidepreventionlifeline.org/how-we-can-all-prevent-suicide/>

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*Duplicated

Teen Suicide Risk Factors⁷: A recent or serious loss • A psychiatric disorder, particularly a mood disorder like depression, or a trauma-and stress-related disorder • Prior suicide attempts increase risk for another suicide attempt • Alcohol and other substance use disorders, as well as getting into a lot of trouble, having disciplinary problems, engaging in a lot of high-risk behaviors • Struggling with sexual orientation in an environment that is not respectful or accepting of that orientation • A family history of suicide is something that can be really significant and concerning, as is a history of domestic violence, child abuse or neglect • Lack of social support • Bullying We know that being a victim of bullying is a risk factor, but there’s also some evidence that kids who are bullies may be at increased risk for suicidal behavior • Access to lethal means, like firearms and pills • Stigma associated with asking for help • Barriers to accessing services • Cultural and religious beliefs that suicide is a noble way to resolve a personal dilemma

⁷Source: <https://childmind.org/article/teen-suicides-risk-factors/>

If in a crisis, youth between 10 and 24 years old can call or text 2nd Floor Youth Helpline at 888-222-2228 and visit their website www.2ndfloor.org

OR

People of any age can call the NJ Suicide Prevention Hope Line at 1-855-654-6735, text at njhopeline@ubhc.rutgers.edu, or visit their website www.njhopeline.com

Additional resources include:

- PerformCare (provides linkage to various services for children):

1-877-652-7624

www.performcarenj.org

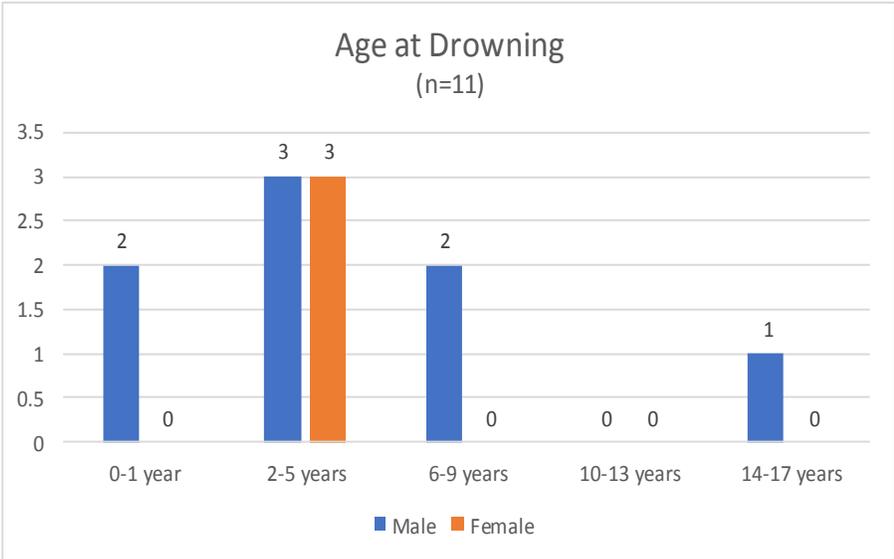
- Mobile Response and Crisis Screening: 1-877-652-2764

- National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

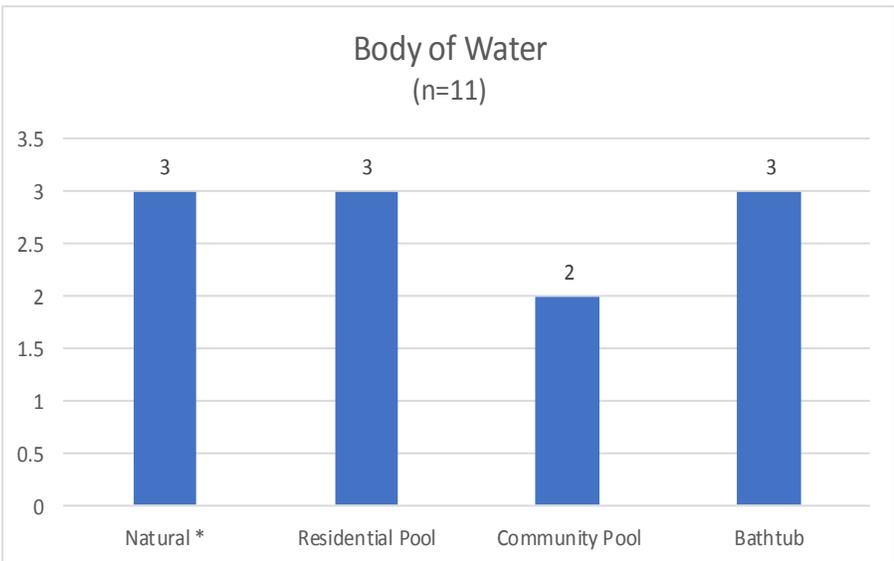
www.suicidepreventionlifeline.org

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DROWNING



There were no drownings for the age group 10-13 years old.



*Natural includes lakes, rivers, and the ocean

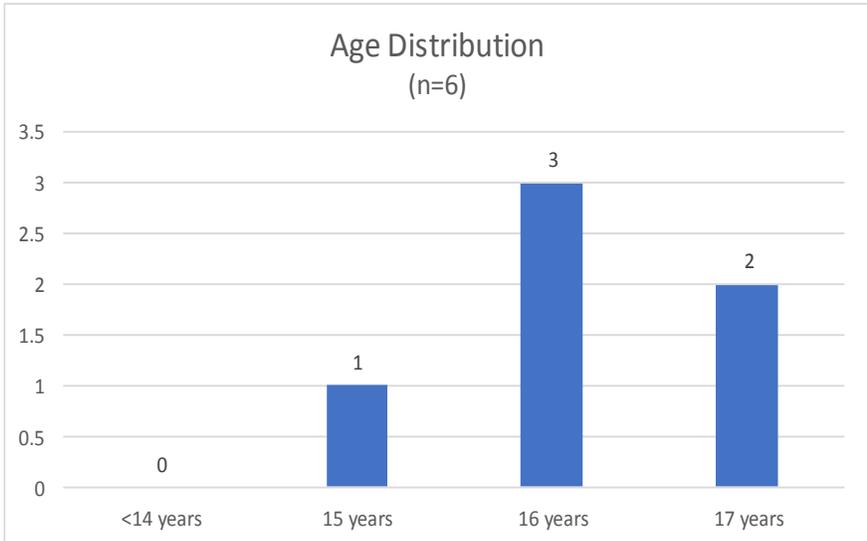
Water Safety⁸:

- ◆ Never leave children in or near water unattended; stay within an arm's length of small children in water to protect against rapid drowning.
- ◆ Warn children to never swim at a pool or beach alone or without a lifeguard.
- ◆ Train children to swim at an early age.
- ◆ Teach children that swimming in open water is far different than swimming in a pool.
- ◆ Be certain only qualified and undistracted adults are entrusted with supervising children in water.
- ◆ Always empty inflatable pools, buckets, pails, and bathtubs after each use.
- ◆ Personal flotation devices do not guarantee water safety.

⁸<http://nj.gov/dcf/families/safety/water/>

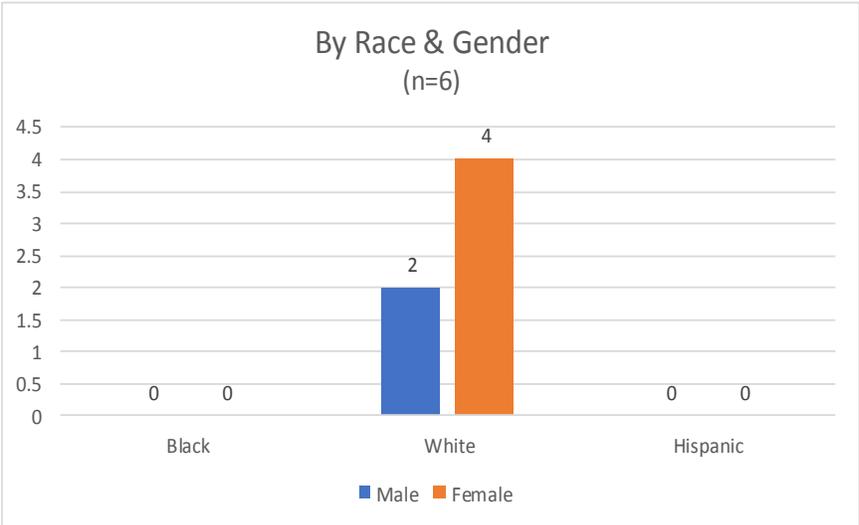
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SUBSTANCE USE



All Manner of Deaths due to Substance Use were deemed Accidental.

Call **PerformCare** at 877-652-7624 to access child behavioral healthcare and other services
 OR
 Call the **NJ Mental Health Cares** hotline at 866-202-4357 for referrals to services



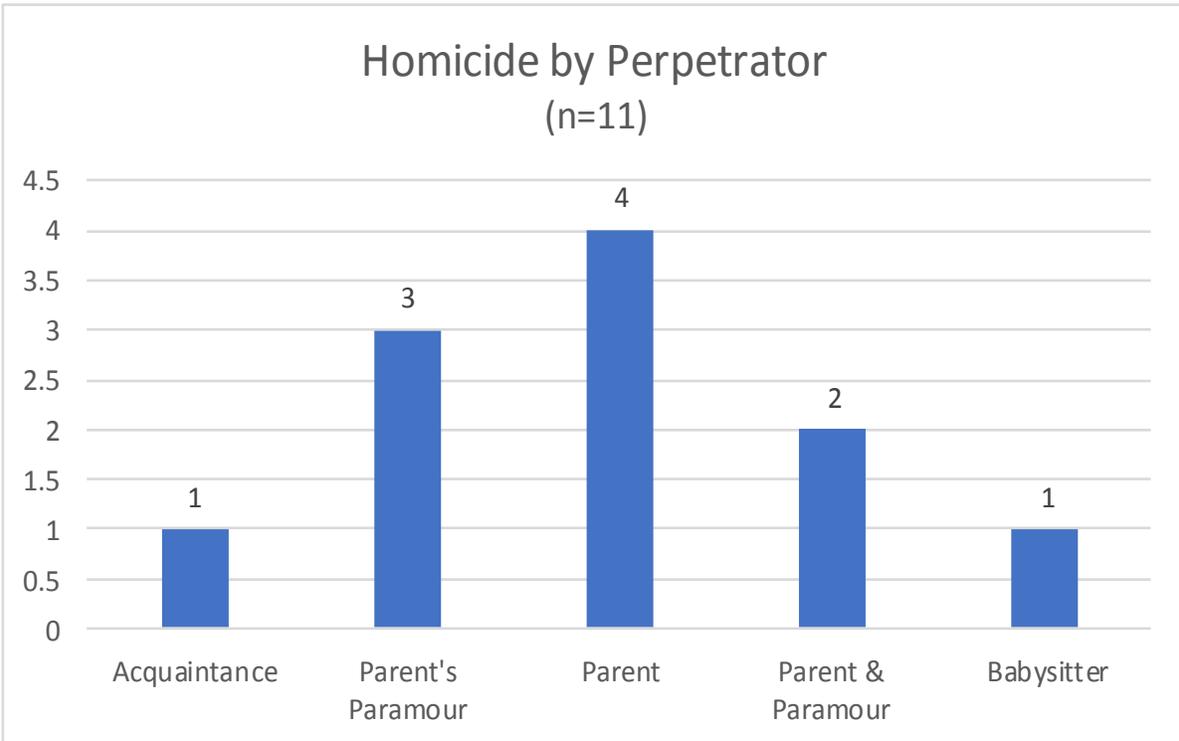
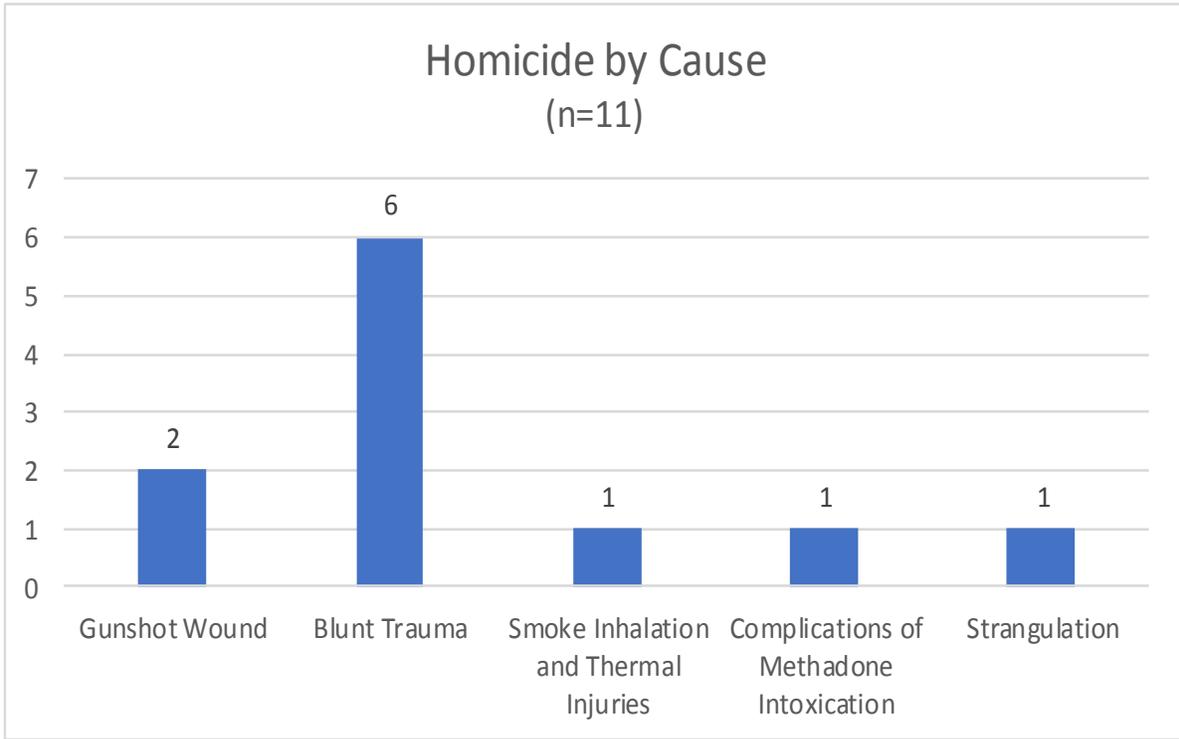
Warning Signs⁹: Changes in mood • Academic/school problems • Changing friends and a reluctance to have parents/family get to know the new friends • A "nothing matters" attitude • Finding substances (drug or alcohol) in youth's belongings • Physical or mental changes (memory lapses, poor concentration, lack of coordination, slurred speech, etc.)

Warning signs indicate that there may be a problem —not that there definitely is a problem. Speak with the youth to get a better understanding of the situation and have the youth screened for substance use by a professional. If formal intervention is necessary, local substance abuse professionals should be contacted. If there is no clear evidence of substance use/abuse, consider working with your primary care physician or a mental health professional to address the child's behaviors and needs.

⁹Source: <http://youth.gov/youth-topics/substance-abuse/warning-signs-adolescent-substance-abuse>

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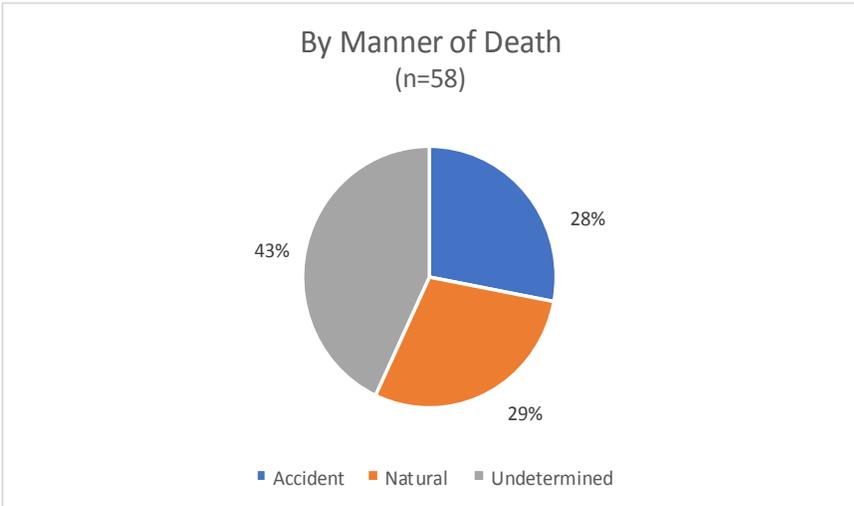
HOMICIDE



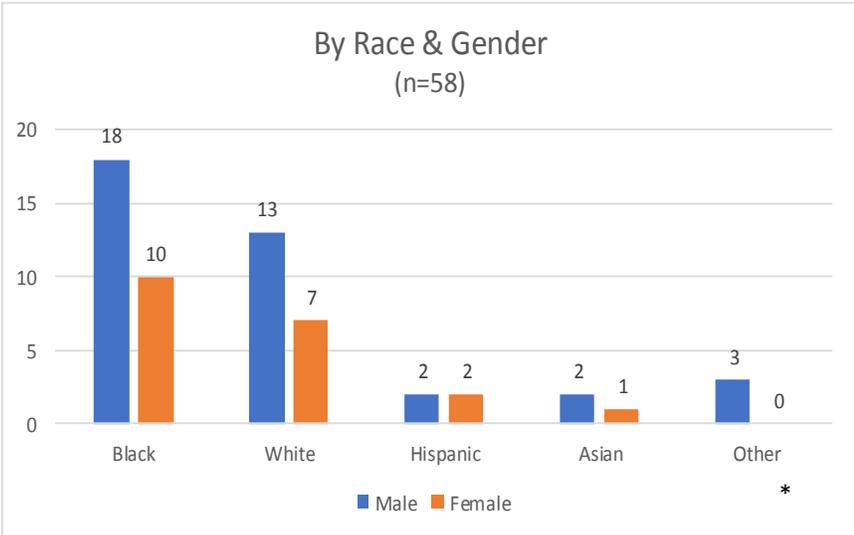
- ◆ The two children who died by gunshot wound were between the ages of 8 and 10.
- ◆ Four of the homicide victims were female and seven were male.

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SUDDEN UNEXPECTED AND SLEEP-RELATED DEATHS

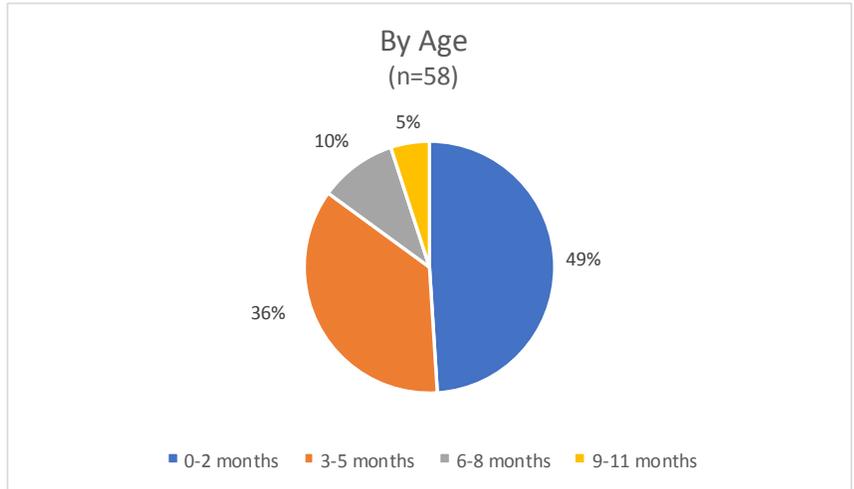


According to the Centers for Disease Control and Prevention (CDC), Sudden unexpected infant death (SUID) is a term used to describe the sudden and unexpected death of a baby less than 1 year old in which the cause was not obvious before investigation. These deaths often happen during sleep or in the baby's sleep area¹⁰.



¹⁰<https://www.cdc.gov/sids/AboutSUIDandSIDS.htm>

*Other includes multi-racial and bi-racial children.

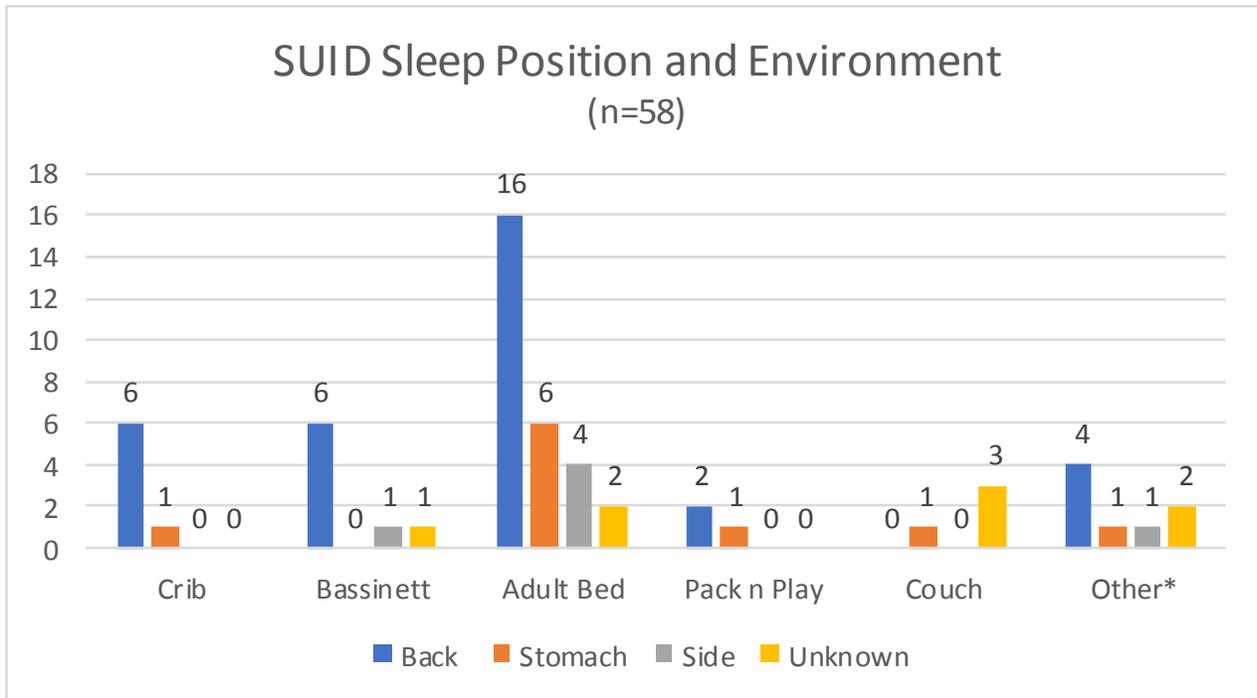


<https://www.babyboxuniversity.com/>

All data represented herein, including all charts and graphs, unless otherwise specified, was collected during the review process of the 2016 fatalities and near fatalities and analyzed by DCF liaisons to the CFNFRB.

SUDDEN UNEXPECTED AND SLEEP-RELATED DEATHS CONT.

Sleep-related infant deaths are those where the sleep environment was likely to have contributed to the death, this includes SIDS, SUID, suffocation, and other causes.



*Includes 1 mattress on the floor, 1 stroller, 2 swings, 1 ottoman, 1 floor, and 2 in the parent's arms.

52% (30) of the infants were sharing a sleep surface with another person.

98% (57) of the fatalities reviewed by the SUID Subcommittee were related to sleep and/or the sleep environment.

Guidelines for Safe Sleep¹¹:

- ◆ Bare is Best: Place baby on the back to sleep in a crib free from objects (i.e. toys, stuffed animals, and blankets)
- ◆ Place baby on a firm sleep surface
- ◆ Place baby in the same room with you but not the same bed
- ◆ Limit baby's exposure to smoke (cigarette, cigar, illegal substances)
- ◆ Consider breastfeeding
- ◆ Bring baby to the pediatrician for all well-visits
- ◆ Practice supervised, awake 'tummy time'
- ◆ Avoid overheating
- ◆ Avoid products such as wedges, positioners, and bumpers

¹¹www.healthychildren.org

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RECOMMENDATIONS

After the review of the 141 child fatalities and near fatalities that occurred in 2016 it is evident that there is a need for improved communication across systems and jurisdictions. In too many of the fatalities and near fatalities there was an identified missed opportunity where two or more systems failed to communicate, and it resulted in minimal or zero information-sharing. Cross-system collaboration is necessary to ensure that the many different entities involved with a child communicate information effectively, as this could potentially save a child's life.

This collaboration needs to exist between agencies, across state lines, and between sister CP&P local offices, as well as between different disciplines, such as child protection, schools, and physicians. The Board recommends that this collaboration occur from the governors' level all the way down to front-line workers, to make a real impact.

This recommendation is in alignment with the National Commission to Eliminate Child Abuse and Neglect Fatalities' report *Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities*. There needs to be real-time data-sharing to have an immediate and beneficial impact on decision making vis-à-vis the lives of children. Protecting our children, the most vulnerable of our citizens, is everyone's responsibility.

Suicide

Suicide screening tools should include a question about a child's involvement with any other entity or agency. In planning with a suicidal youth, every safety plan should address reducing access to any lethal means available to the youth.

Drowning and Water Safety

Increased public education on water safety, including bath tub safety with infants, is needed.

Sudden Unexplained and Sleep-Related Infant Deaths

57 of the 58 SUID cases reviewed were related to sleep or the sleep environment. It is extremely important that all unattended infant deaths have a thorough death scene investigation to determine what occurred, as this may prevent future SUIDs. The Board recommends that training be required for medico-legal death scene investigators on how to accurately complete a SUIDI form and on comprehensive questioning regarding an infant's sleep environment.

Substance Use

The Board continues to support any efforts on the part of law enforcement, child protection, or any governmental entity, to decrease issues of gun violence, drug addiction, and poverty, including the increased access to training for professionals in these fields, as well as the promotion of community-based programs in environments stricken by these issues, to encourage healthy family relationships and steer children away from gang-involvement.