



COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

SAN ANTONIO, TEXAS PUBLIC MEETING TRANSCRIPT June 2-3, 2014

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Dr. David Sanders: [001-00:00] ...bring here in San Antonio, Texas. This is our first public hearing in the state, and we have several others planned in the upcoming months, but really are excited about the opportunity to be here in Texas and to learn, and I want to start by thanking Congressman Doggett for the invitation. As a Commission, we were created by the Protect Our Kids Act in 2013, and really are on a journey over the next year and a half to reduce and ultimately eliminate child abuse and neglect fatalities. We'll do that through engaging in a national dialogue regarding

this issue through hearings like this, and that's why the one here in Texas is so important, and eventually produce a report for the President and Congress.

We'll first need to determine how to best measure the number of fatalities due to abuse and neglect. If we don't know the scope and don't know how to count, it's difficult to know what works and what doesn't.

Second, we need to know what works and what doesn't, and how Congress and the Administration in particular can support what works in states and not waste resources on what doesn't.

So the agenda over the next two days here in Texas will address three very broad issues. Let me quote from the Protect Our Kids Act, which established the Commission, "The Commission shall conduct a thorough study on the use of Child Protective Services and Child Welfare Services funded under Title IV and Subtitle A of Title XX of the Social Security Act to reduce fatalities from child abuse and neglect.

So the first broad issue that we'll be looking at is relevant policy, and we'll have extensive presentations today on policy in Texas as well as tomorrow on federal policy.

The second broad issue, and again I'll review from the legislation, the legislation identifies six matters for us to study, and the second of those speaks of systems aimed at collecting accurate, uniform data. So the second broad issue is we'll hear research on what we count and how we count. So the second issue is research.

And then finally, Congress was pressing in its emphasis on location of hearings across the country, quote from the legislation "The location of hearings shall include (a) areas with high fatality rates from child abuse and neglect and (b) areas that have shown a decrease in fatalities from child abuse and neglect." The State of Texas has the highest absolute numbers of fatalities due to child abuse and neglect of any state and one of the highest rates. At the same time, this region, Bexar County, has seen a sharp decline over the past year in the number of fatalities due to abuse or neglect. So we'll have an opportunity to hear about practice and policy in Texas. So the third broad issue is practice. Within this we'll hear from multiple perspectives in the state from child welfare, from law enforcement, from health and public health.

The three areas of focus will be what works and doesn't to reduce child fatalities, and what can the federal government do. Second, how are fatalities counted in Texas, and third, how does the state deal with confidentiality.

In a minute I'm going to ask Dr. Martell Teasley, who is a professor and Chair of the Department of Social Work in the College of Public Policy at the University of Texas, San Antonio to welcome us. He'll be followed this afternoon by Dr. Rachel Berger, the Division Chief of the Pittsburg Child Advocacy Center at Children's Hospital at Pittsburg on what we count, and she is also the research lead for the Commission, and Dr. Sam Gulino, who is the Chief Medical Examiner for the City of Philadelphia, on how we count. In other words, they will present the research issues for us.

But before proceeding further, I'm going to ask each of the Commissioners to introduce themselves very briefly, and maybe we can start with Commissioner Zimmerman.

Marilyn Bruguier Zimmerman: [001-04:30] Good morning. My name is Marilyn Bruguier Zimmerman, I'm an enrolled member of the Fort Peck Assiniboine and Sioux Tribes. I currently serve as the Director of the National Native Children's Trauma Center at the University of Montana.

Michael Petit: [001-04:32] I'm Michael Petit, at the present, founder of the Every Child Matters Education Fund, based in Washington D.C., a national organization, and before that I was with the Child Welfare League of America, and the Maine Commissioner of Health and Human Services, which had responsibility for child protection.

Theresa Martha Covington: [001:04:36] Good afternoon, I'm Terri Covington. I'm the Director of the National Center for the Review and Prevention of Child Deaths, which supports states and their child fatality review efforts.

Dr. Cassie Statuto Bevan: [002-00:06] Hi! Cathy Statuto Bevan. I am with the Field Center on Children's Policy, Practice and Research, and I am thrilled to be here and I hope I can learn a lot from you. Thank you.

Dr. Sanders: [002-00:21] I'm David Sanders, the Chair of the Commission.

Hon. Patricia Martin: [002-00:25] Good afternoon. I'm Patricia Martin and I'm the presiding judge of the Child Protection Division in Chicago, Cooke County, Illinois.

Dr. Wade Horn: [002-00:34] Good afternoon, I'm Wade Horn. I'm a Director with Deloitte Consulting, where I have our Human Services Practice. I'm also a clinical child psychologist by training and in the past I was the Assistant Secretary for the Administration for Children and Families, in the U.S. Department of Health and Human Services.

Amy Ayoub: [002-00:54] I'm Amy Ayoub from Las Vegas, a child advocate.

Jennifer Rodriguez: [002-00:59] I'm Jennifer Rodriguez, the Director of the Youth Law Center. We're a national child advocacy organization focused on improving the lives of youth in the juvenile justice and child welfare system, and my personal connection is that I grew up in foster care in California.

Dr. David Rubin: [002-01:18] And I'm David Rubin, I'm a general pediatrician from the Children's Hospital of Philadelphia, and I co-direct a center called Policy Lab where we use research dynamically within public systems to make sure that the programs and policies we choose for children are informed by the best research.

Dr. Sanders: [002-01:34] And I believe Bud Cramer was going to join us by phone, he's not on yet. Before bringing up Dr. Teasley, we're very happy to announce that we've actually launched the Commission's website. And so we have over 100 members of the public here in person or on the telephone, and we really do welcome the

members of the public who are here as well as those who have joined us by phone and thank them for taking the time to be part of this very important discussion. And so we will not have the opportunity for oral public comment, but public comment can be submitted in writing, and I was going to just do that by hard copy right on a piece of paper, but we actually have a website now, so the website is at <http://eliminatechildabusefatalities.sites.usa.gov/> and I believe we have it up here for those in the audience to see. And you can actually send us comments through the Contact Us section of the site. This site is just launched today, and we look forward to the opportunity to interact with people and the public from that site.

For speakers and Commissioners, this meeting is being recorded so remember to speak directly into microphones. And for the Commissioners throughout the two days, we'll have speakers complete their comments within prescribed timeframes, and for each of the speakers we will have time afterwards for questions. In addition, if there are questions that you aren't able to get to I think everybody has index cards in front of them and can write some of those down, and we will make sure that the presenters get them and can send us back responses in writing. And I'm not sure that Dr. Teasley is here. If not, we will get started with Dr. Berger.

Dr. Rachel Berger: [002-03:50] Thank you for allowing me to speak today. As David said, my name is Rachel Berger. I'm a pediatrician at Children's Hospital, Pittsburg and the head of the Child Advocacy Center there, and also research staff member for the Commission.

So what I want to talk about for the next 30 minutes or so is about what we count, what should we count, and why do we care so much about what we're counting. So I'm going to make sure I leave plenty of time for discussion at the end.

So what do we count? We know we're counting deaths, which although that may sound a little funny, we all agree on what death is, and so that is really almost the only thing, as you're going to see, that we absolutely agree on unequivocally. But the things we have to question are what is a death due to child maltreatment, and who decides if a death is due to child maltreatment?

So as I'm going to say several times during this presentation, it depends on where you live what a death due to child maltreatment is. So at the top here is the definition by CAPTA, which is "Any recent act or failure to act on the part of a parent or caretaker which results in death." And it seems like this is fairly straightforward, although I'm sure we could all pick out words, such as what is "recent," right? What's the definition of "recent"? What exactly is a "caretaker"? And if you look at each of these states, Georgia is another one, there is the word "accidental." What is an accident? I think we'd all agree, for example, that a child being hit by lightning is an accident. But what if the child is unsupervised and goes into a pool while there's a thunderstorm and then gets hit by lightning? Is that still an accident? So even a term like "accident" is loaded and has a lot of different meanings, and it may depend on who is interpreting it on that day or in that state.

And then who decides if the death is due to child maltreatment? Again, it depends on where you live. And I just took three states, but all of the states have similar, slightly different definitions. In Alaska the Medical Examiner decides it. In New Jersey, it's the

DYFS or the CPS Director. And Dr. Gulino is going to talk a lot more about the differences between the medical examiner's CYF and different people who decide on whether a death is due to child maltreatment.

And then the other issue is how sure do you have to be to call something abuse? It's, unfortunately, not a dichotomy, it's either abuse or it's not abuse. It's not that simple. And so it really depends, again, on where you live, and states use a different level of evidence. So about 36 states use the idea of a preponderance of evidence, and other ones use credible evidence or reasonable evidence, which is probably about the same. Kansas, for example, uses "clear and convincing" evidence, which is a much higher standard. So the number of deaths in that state is probably going to be a lot lower because the standard is higher. And Pennsylvania is an interesting state because we have used "clear and convincing" for the last several years but now we have new legislation, as of January 2015, where we're going to revert back to a lower standard. And so in Pennsylvania it may appear like we have more fatalities due to abuse but it's only because we've now changed our standard. So even within the same state things can change. But importantly and intentionally, all of these standards are below the criminal standard, which is beyond a reasonable doubt. So it just shows you that even within maltreatment there are many, many levels of how sure we are.

So I want to show you something called Leventhal's Triangle. So John Leventhal is a professor at Yale University and one of the leaders in child maltreatment, and he developed this triangle to really help physicians think about and explain to others how we make decisions and how we think about cases. So what this triangle shows is that on the top we have accidents. And these are things we all agree are pure accidents that were completely non-preventable. At the bottom we have cases of absolute abuse and clear neglect. And the first question we always ask is, "Where is the level of reasonable suspicion where a mandated reporter should report?" And he says he puts the line here, where this is a mandated reporter. But from person to person that's going to change significantly, and I may be the type of physician who says, "Unless I'm sure it's abuse I'm not reporting it," and my line is going to be up near the top, right? Or I may be someone who says, "I'm going to report everything!" and then I'm going to report almost everything in that triangle.

But then the question is of all the ones that are reported how do we decide what child maltreatment is? And again, he draws this line of probably maltreatment. But clearly this line is going to be different for different people, potentially in different circumstances, and certainly in different states where the line for what is abuse is going to be different.

And the other thing we have to remember is the line isn't always straight. So we find a lot that people are more willing to call something abuse or to call an act of commission abuse than they are to call an act of omission neglect. So for neglect sometimes people have a much higher standard and are way more likely to call something a "horrible tragedy," therefore even across that line they may call it an accident and it really has to be close to unequivocal neglect for somebody to call it neglect.

And now we go to the Leventhal Triangle for child fatality. At the top we have non-preventable death. These are absolute accidents and we all agree on that. At the

bottom we have the whole spectrum of potential deaths from maltreatment. I put filicide all the way on the side because that's, as I'm going to talk about, an intentional death of a parent on a child, and that's important because as you go all the way to the other end you get to the end where we have "unsafe sleep." And I think this is kind of the spectrum of where we can look at all the different types of deaths due to maltreatment. Again, we have a line for reporting, but more importantly for this Commission is where is the line where we want to count it? Do we want to count it here? What if we count it way up here, right? And then all of a sudden the number of fatalities is going to get really, really high. Is that good or bad? Well it's not good or bad it's just we have to understand where we drew that line, and maybe we draw the line this way. Maybe it's not straight across. Maybe we have a different threshold for neglect deaths than abuse deaths, and maybe we put it way down here. And if we put it way down here we're going to have very low numbers of child maltreatment because we're really not including very much. So I think this just gives you an idea of a way to think about where we want to draw the line, and to understand that at some point you do have to draw a line because otherwise you can't count. And it's problematic if everybody wants to draw the line in a different place because then you don't know what everybody is counting.

So I want to just briefly touch on filicide. This is a topic we've decided we're going to touch on again in a later Commission meeting. Filicide is when there is a deliberate act of a parent in killing a child. This is like a mother who drowns her children or a father who shoots the children. And I think everybody agrees that this is child abuse and we should all count it, but importantly there is a very small number of these cases, and probably these are the least preventable of all of the cases that we have. Really, there is the least amount of evidence. But I think it's an important issue to discuss because it is the far end of the spectrum of where we're all going to agree this was intentional, and that this caused death, and that this is abuse.

What's a death due to physical abuse? This is any death with an abusive head trauma, an abusive abdominal injury, burns from abuse, or potentially a battering. So the question becomes should children who die from these injuries always be counted as having a death due to maltreatment? But the reality is sometimes there are a lot of other things that are taken into account. So are there situations where we shouldn't count these? What if the perpetrator is very remorseful and say they didn't mean to kill the child? What if there's been no prior contact with child protective services? What if there's no children who are still living after this one child dies? What if the medical expert says unequivocally it's abuse but the coroner says the manner of death is undetermined? Or what if the police prosecute and the caretaker is convicted but child protective services doesn't substantiate? Should we be counting these cases? And I would argue that in every single case, regardless of these, you still have a child who's dead, and the child has died from something which is not an accident and which is child abuse. However, currently all of these situations are one in which certain states and certain localities would not count the child abuse because of their own statutes about child abuse. So I think the one that we all know most about is many states don't report if there has been no prior child protective services intervention.

So I'm going to move to supervisory neglect. So what is supervisory neglect? Again, as I've said before, it depends where you live. These are four different states, and I'll put Texas at the end. In Kentucky it's a pattern of conduct. So in Kentucky you have

to do multiple things in order for something to be called neglect. In Pennsylvania, we've just passed a brand new statute which states that it is "a repeated, prolonged" or, for the first time, allows for "a single unconscionable egregious act." And this is different than what Pennsylvania has because previously, like other states, it had to be a pattern, but now a single act that is egregious and outside of anything that you would consider normal is now considered to be neglect. In Texas, interestingly, they use the "reasonable person" standard, which is actually used by quite a few states, so what a reasonable person would know that this is was an inadequate amount of supervision for this child.

So what kind of deaths are we talking about when we say "supervisory neglect"? These six cover most of the types of deaths: fire-related deaths, drowning, gun-related deaths, drug ingestions (legal or illegal), falls (such as falls out of windows), and exposure to heat and cold. So the questions that often get discussed in fatality reviews or sometimes near-fatality reviews are how long is too long to leave a child alone? Does it matter how old the child is? I think we'd all say yes. Does it matter if you live in the country or you live in the city? Does it matter if there are other siblings in the house to watch those children? What if the parent is impaired by drugs or alcohol? Should that change whether the death is considered to be counted and due to neglect? And does it matter how long? We often talk about, in drowning, it was only five minutes versus it was 15 minutes, but the reality is the child can drown in well under five minutes, and even if it had only been five that would have been enough. So I think that's another thing we have to think about.

And how about patterns? The law certainly says that patterns appear to matter, but what if CPS has been involved multiple times for some low-level concerns and then the child dies? Is that different than a single, as Pennsylvania says, egregious act?

For drug ingestions we often talk about does it matter if it's cocaine or if it's a prescribed cefaxone drug? And does it matter if the child got unlucky enough to ingest a drug where you only need a tiny bit of that drug to kill you versus a drug where you had to get a lot of it to kill you? Does that matter? And are there certain situations which are simply neglect regardless of any of these other situations, like leaving a 6-month-old in a bathtub by themselves, or leaving a child with access to a loaded gun?

So as you can see, these aren't black and white, and you can see how different groups would come to different conclusions in different locations and even in the same location at a different time period.

So I want to give you a couple of examples. The first two are gun deaths, and these are differences in how different cases were counted, and the cases really seemed to be quite similar on the surface. The first one was a 2011 unsubstantiated case, so not substantiated by child protective services. The 3-year-old found a gun and shot himself. Law enforcement finds bullets in the closet, a piece of crack cocaine floating in the toilet, numerous items of drug paraphernalia, and the house in disarray. It was not substantiated by CPS because they felt it did not reveal substantial evidence of serious physical injury as a result of the lack of supervision on the part of the mother, who was the caretaker. Criminal charges were filed against the drug dealer who was in the home when the child got the gun, but they felt that the mother was not at fault.

And so although that person was prosecuted in the criminal system, it was not counted because the mother was the caretaker and she was not felt to be neglectful.

In the same year, in the same state, another case was substantiated and it was a 4-year-old who found a gun and shot himself. He found a loaded gun, he killed himself, family was not known to child protective services, and there was no drugs or alcohol involved.

Here's another case from 2012, also not substantiated, and in this case the 19-month-old shoots himself, the mother is attempting to unload the handgun that she was selling to a former drug dealer, the family was the subject of a prior report to CPS very recently, and it was unsubstantiated because they felt that the mother did not intend for the bullet to come out of the gun. Interestingly, this mother had a previous child removed by child protective services and she did not have that child.

So sometimes I read these cases and I almost can't understand. And I think sometimes when you try to think too much about it, it doesn't make any sense. Some of these you simply look at them over and over and you say, "I don't understand what the difference between one and the other is." I think it's a different group of people at a different time, and potentially in a different place looking at different things in a different way.

Here is one due to drowning. This one was in 2013 and was substantiated. It is a 1-year-old left in the bathtub with the siblings, one who is 9 months older and a 3-year-old. It was 5 to 10 minutes. The mother says she was relying on the 3-year-old to tell her if something went wrong. The father was playing video games, the mother comes back up, the child is under water, and the child dies. That is substantiated.

An unsubstantiated drowning is a 3-year-old who is in the family pool, the child has a life vest on, or so the family says, there was an 8 to 10 minute period where the adults did not see the child, then found the child without the vest on under the water and the child died. And it was not substantiated because it was felt that the child was in a blind spot where the mother and the aunt were and they could not see her. Interestingly, during this investigation, it turned out that a year prior that child had been wandering by themselves and the police had actually become involved, but CPS didn't know about it.

So it's interesting because in the first case the mother leaves the child in a bathtub for probably 5 to 10 minutes and we substantiated it, and it counted, but in the second case it's a family pool, it's 8 to 10 minutes, which is even a little bit longer, and neither of those children swim, neither the 1-year-old nor the 3-year-old, but in that case it's not substantiated.

Moving on to medical neglect, I only want to touch on this very briefly because, although medical neglect does depend on where you live, it probably depends on where you live less than other types of maltreatment. There is a fairly standard definition of medical neglect. It usually is a failure to heed obvious signs of a serious illness or failure to follow a physician's recommendation. Then there needs to be certain things followed, and they are slightly different from state to state. What makes it different, though, is the way it is interpreted from state to state. So what if

the family has a religious belief and that impacts their medical decision-making? For example, in Pennsylvania, if a child dies due to lack of seeking medical care it is considered abuse. However, if the child does not die and is seriously injured it is not considered abuse at all and is taken care of outside of the child protective services system. What if there is family chaos and disorganization and this death occurs in this chaos? Or what if there is a lack of trust in physicians because of prior experiences with that patient or that patient's family? And what if there is cognitive impairment of the caregivers? So these are all things that make the medical neglect very complicated because it's not simply just the physician says this child shouldn't have died.

And I think we have to touch on the issue of unsafe sleep, because this raises a really important issue of cultural norms as it relates to preventable death. Because sometimes what we used to think of as not preventable may actually be preventable as the research moves forward. So when babies used to die during sleep we called it SIDS, sudden infant death, but then people who were studying SIDS noticed that many of these babies were found on their stomachs, or in waterbeds, or with pillows, or other forms of things that were stuffed. So in 1992 the American Academy of Pediatrics recommended that babies sleep on their back or their side, and actually in 1996 they updated it and said actually only on the back. And in 1994, NICHD and NIH launched the "Back to Sleep" campaign. And as most of you know, this has been one of the most successful public health campaigns we've had, and the instance of what we used to call SIDS has now dropped by more than 50 percent. So people have started to say, "Well wait a second, what really is SIDS?" Because most of what we thought was SIDS was probably what we now think of as unsafe sleep, and it actually is a preventable death not a non-preventable death. So then we get to the question of when is putting your baby on the belly a type of neglect? And this is very complicated, because clearly not every baby who sleeps on their belly is going to die of SIDS or clearly nobody would sleep their baby on their belly. But also, every child who is left alone in a pool doesn't drown. And this is why neglect is so difficult, because many, many children are put in these situations but don't die. So at what point do we say, "Okay, now this is not acceptable when there is a poor outcome." So should deaths due to unsafe sleeping be counted? And I will say, if you think about there are many, many other cultural norms we've changed. Probably everybody in this room, when we went home from the newborn nursery, sat on our mother's lap in the front of the car, whereas now if you ever saw an infant in a car without a car seat you would pick up the phone and call the police. And we have fewer than 100 deaths of infants in car crashes every year in the United States because what used to be considered, "You just sit on your mother's lap" is now totally culturally unacceptable. So there are changes in cultural norms even as it relates to fatalities.

So there are cases now that CPS is substantiating and are being counted that are clearly cases of unsafe sleep. In this one, it is a 3-month-old who dies and they call it "an avoidable tragedy." The child's mother had been co-sleeping, the mother had seven children, had been educated about the dangers, including from the pediatrician, and the case indicated as neglect. And interestingly, in a report by the Michigan Department of Human Services, in the 2009 and 2010 reviews a larger percentage of the deaths attributable to neglect were in infants, and when they looked at those deaths it is because the local review teams were starting to call sleep-related deaths neglect deaths. But we have to remember if some places are counting and some places aren't we have a very difficult view of what really the face of unsafe sleep is in the

United States, and what is maltreatment, or is that neglect, and how we should be counting it.

I think the other thing we really have to think about is if we count these, is the counting itself changing the culture? If we say that this is important enough that we should count it is that, in and of itself, saying, "This can no longer be counted as a tragedy or an accident." So of course the question is why does this all matter? We obviously want to prevent death due to child abuse and neglect, and the goal of this Commission is clearly to eliminate deaths from child abuse and neglect. But in order to do evidence-based interventions, which prevent these deaths, we have to have high-quality, consistent data about all deaths, or at least a completely random sampling of deaths. We need to know how many children die and why they died in order to keep other children from dying, and in order to measure the effectiveness of intervention. The non-random sampling of cases, which is really what we have now, creates a bias, and with that kind of bias we can't really understand what the true risks to children are. So an example is if we only count cases where we have prior CPS involvement this creates a huge bias in our sample, because children who are killed despite CYF involvement are probably a very different group than children who die who have never been involved with child protective services. But if we only look at the data from children where there has been prior involvement the conclusions that we draw may not be appropriate and the interventions might not be appropriate.

So what system will let us do what we need to do? We need to collect data about the circumstances and the system has to be set up for the benefit of children. It needs to be a child-centric system. And if there is any system in this country which should be child-centric it should be a child protective services system. It can't be for the benefit of parents. Many times we see CPS or another agency not call something abuse because the death of the child is seen as punishment enough for the family. We tend to label many neglect cases as "tragedies" because sometimes, with neglect cases, I think many of us could see ourselves in those same situations. I don't think there is any parent who hasn't done anything stupid in their entire parenting life. When they don't sometimes look back and say, "Oh my gosh! That was a really bad thing to do! I am so lucky that nothing happened!" And so I think it becomes very difficult sometimes for us to want to label and to call something neglect or abuse when we could put ourselves in the shoes of that parent. We can't not label something because investigators say "There, but by the grace of God, go I," kind of frame of mind, which again, this is very similar to this idea of neglect cases. It can't be because various systems are afraid of being blamed for their actions, or because they are trying to meet certain requirements. So for example, if we have a requirement that when a child dies in NCANDS you have to report where there has been family preservation in the prior 5 years. And we all understand why that requirement is there. But then you have an agency that has put in a tremendous amount of family preservation and the child dies. Whether people want to or not there is a disincentive to call that death a death due to abuse because there is this other link to this family preservation, which we said you have to report. So we have to be very careful about whether by counting something it changes something else in the system, or something else that is being counted.

So we have to think about how we currently count. And I think as a society the system we have now doesn't really reflect the importance of this problem or really how

important we all think this problem is. We say that supplying data to NCANDS is voluntary, but what do we say if the system that is collecting the most important data is not required, that you can do it if you want to but we're not going to give you any extra money or anything to do it, you just should be doing it. CAPTA doesn't require interdisciplinary reviews, which is something Dr. Gulino is going to talk to. It encourages it, and states now need to say what sources they look at, but from county to county and state to state people are including very different data sources. And then again, as we talked about, there are huge variabilities in what is counted. Some states don't count if the family was not involved with CPS. Some don't count if there are no siblings. Some don't count if the perpetrator is now dead and there is no risk to other children. And some states, such as Pennsylvania, which is where I'm from, have a very narrow definition of a perpetrator. And I don't think I'll ever forget a case from about five years ago where a child died of abusive head trauma and the mother's drug dealer did it and it didn't count because the drug dealer wasn't a perpetrator under child protective services laws, but the child was dead and it was probably a preventable death, and that child doesn't show up anywhere for us to look at risk factors, for example, related to selling drugs in the home. So it is very easy for cases that are unequivocally abuse not to count. Pennsylvania has never counted cases where there is an unknown perpetrator. So if you have an abusive head trauma and the child dies, if you don't know if it is mother or father, that doesn't count, and it has never counted! Starting January 1st, 2015, with the new legislation, it will count. And all of a sudden Pennsylvania is going to have a lot more fatalities but not because more children are dying, but because we are finally counting these cases where we don't know who did it. And obviously, when you think about it, it makes no sense, that if you don't know who did it, it doesn't count. It is just the way the law has always been, and in Pennsylvania the perpetrator registry has always been linked to the child abuse registry, so you had to have a perpetrator in order to have an abused child. That is just how it came about.

So how do we develop a system that is a child-centric way to count deaths? I don't think there is a quick and easy way to do this. I think we have to start a conversation about why it is so important to count all these deaths, and then we have to develop a consensus about what do we have to count. Once we start doing this, we have to recognize the problem may look worse than we think it is, because if we start including more things the numbers might go up and we just have to be aware of that. Pennsylvania really is bracing itself because of all of its changes, but our numbers are going to look worse, and it's not because the system is doing a bad job it is because we changed the laws.

I want to suggest an approach which has been used with a very specific type of abuse, and this is the CDC's look at abusive head trauma. As most people know, abusive head trauma is a leading cause of death from child abuse, and routine surveillance of abusive head trauma has really been limited because it is a very variable definition. But what is different in abusive head trauma is virtually all children are in a hospital except for the small percent that die and go to a coroner. So about 10 percent of the kids never reach a hospital. But this is meant to look at the 90 percent of children who do go to a hospital. In March 2008, the CDC had an expert panel to develop code-based case definitions, so medical codes when doctors said on their medical code, "This is abusive head trauma." And the panel had two different definitions. One they called the broad operational definition, which was really for sensitivity, getting all the cases

and what they felt was for population-based surveillance. And then they had a narrow definition, and this was the cases we were absolutely sure were abuse, there was no discussion about it, and it was really about specificity. And this was really for very focused assessments on very specific types or parts of the abusive head trauma issue.

So the question is could we do something similar for child maltreatment? Could we get an expert panel to agree on what is a broad and a narrow definition of death due to child maltreatment? A narrow definition, for example, would include filicide, most of the physical abuse cases, and probably cases which the child death review team agree on. And maybe the broad definition starts including all the sleep-related deaths, maybe certain drowning deaths where there was some disagreement in the lack of consensus and the child death review. And I think what is important is whether CPS substantiates may not be the critical point, because the problem is that CPS labeling a case has an implication for the parents, who need to get a job, potentially, for the parents who feel, not surprisingly, that somebody is telling them they did something wrong, and there is something to be said for it's a tragedy enough that the child died, and that's a horrible thing. Do we also need to label the parents? Maybe, maybe not, but we still need to count the children. So maybe it has to be outside of a system where there is a secondary issue of labeling or counting. As I said, maybe this needs to be completely independent of our CPS system.

I just want to end with near fatalities because one of the GAO's recommendations is to estimate the cost and benefit of collecting national data on near fatalities. So I just want to touch on this because, although we all agree on what a death is, that a child is dead, we actually don't agree on what a near fatality is. And in addition to not agreeing on what a near fatality is, we still have all the issues we had with fatalities in terms of how sure do you have to be and what state are you in? So I just took a couple of states, and not surprisingly a near fatality is also defined by state, and interestingly, it's the one time where they ask physicians to actually label whether a case is a near fatality.

Here we have CAPTA saying it is "certified by a physician that the child is in serious or critical condition." If you ask 10 physicians what "serious" or "critical" are you're going to get 11 different answers, because I think it's something that the press uses, but we don't really use it as much as a medical term, and so there is a huge variability on what is a near fatality. There are also a lot of questions about, for example, say a child has an overdose of a medication, and that child is very lucky and EMS shows up 5 minutes later and they give the baby Narcan, and they had just injected an opioid and the baby now wakes up and is fine. Another baby in the next county ingests exactly the same amount of drug but their EMS takes another 10 minutes to get there because it's in a more rural area, the baby is now dead. There was absolutely no difference in what those two babies did, but one was a near fatality, potentially, or one was a death, and the other baby is completely fine because they got a reversing drug very, very quickly.

The same thing happens with abusive head trauma. If you are at an institution where people are very aggressive with treating abusive head trauma, and I'm in one of them, we have very few deaths from abusive head trauma, but we have a lot of seriously ill or vegetative children. And that's a medical approach, but there is no difference in the actual injury to those two children. The difference is in what happened after. So

near fatalities are very, very important to study because the risks might actually be exactly the same as the risks from fatalities, but the outcome might be different because of something that is not related to the safety risks to the family. I think the issue is that we have to be very careful that we don't exclude the near fatalities, although recognize it's going to be very difficult to decide on what we should include in here.

The other thing that near fatalities are useful for is that the rate of death from child fatality is a good thing, because it is very, very low. Once you start including near fatalities you have many, many more cases and that actually helps when we're trying to do intervention programs because there are more outcomes to look at and it is easier to test intervention programs. So the idea of including near fatalities might be something that we want to think about.

So in conclusion, we really don't have consistent definitions for what a death due to child maltreatment is. As a result, we have every state, and even different regions in the same state, giving counts for different things. And the three physicians who are talking tomorrow are going to talk about how even within the state of Texas we have different regions with very different interpretations of the same laws. But it is understandable why we have this lack of consensus. The circumstances, just from the cases that I've shown, are very complicated and every case really is different; every drowning is different, every gun shooting is different. And there are cultural norms which change over time and actually it would be very different from different regions of the country.

The unfortunate, or fortunate thing is that the obvious cases, such as filicide, are the exception and not the rule. So the easy cases we don't get very often. And there are many systems that are coming into play here that have different things they are required to count by their own standards, and there are different legal mandates that everybody has. And when all of those things come into play it gets very complicated. So in order to improve our ability to develop evidence-based interventions for child abuse we have to develop this child-centric system of counting deaths and then we can start to figure out what evidence-based interventions can prevent them. So that left me plenty of time for questions.

Dr. Sanders: [009-03:10] Thank you, so Commissioners, we have about 25 minutes for Commissioners' questions or comments. We will make sure everybody has a chance to ask their questions.

Jennifer Rodriguez: [009-03:16] I have a question out of curiosity. The differences in interpretation on whether a death is child abuse or neglect, has there been any research done on how bias due to race or socioeconomic status plays into that?

Dr. Berger: [009-03:33] So yes, although it depends on exactly what you are looking at. So there is a lot of data about reporting biases, and there are definitely reporting biases based on race and socioeconomic status. There used to be a lot of thought that race really played into whether cases were indicated, whether CYF got involved in cases. But interestingly, as time has gone on, and some of Emily Putnam Hornstein's work, and she is going to be speaking about how with these very large data sets actually shows some things are the opposite of what we thought they were. So

actually, in many of the African-American families, there actually are many, many, many risks, and even unrelated to race, the rate of fatality of child maltreatment is higher, unrelated to race. And in some cases the interventions, the proportion of children removed from homes with similar risk factors is actually lower in African-American children, which is not something that people had expected to see. So Emily is going to speak to this a lot in the next meeting, and some of what she has found in these large data sets actually goes against some of the data that we have had in the past, as we get to these larger and larger, not completely random data sets, or very, very inclusive data sets. Some of the thoughts about this have actually changed. Does that answer your question?

Rodriguez: [009-04:50] Well, I think I'm more familiar, actually, with that research. I was wondering, in terms of classifying deaths.

Dr. Berger: [009-04:54] I don't think there has been anything about whether a death is caused because a person is black or white. Is that what you're saying?

Rodriguez: [010-00:02] Or because a family is poor or well off. I was wondering, in the examples about drowning deaths and guns whether that slant of the reviewers' take on what level of risk the child is facing.

Dr. Berger: [010-00:13] I don't think there has been any good data looking specifically at that issue at the level of a child review team. It is interesting that with drugs and alcohol, like in Pennsylvania, you would think that inclusion of drugs or alcohol in the situation would make one more likely to substantiate, but actually when you look at our data that is not what we see. And what we see is that CPS is saying in this specific instance, at this moment in time this was not a death due to neglect, and they tend to not look at all the other situation, the fact that there was drugs and alcohol, there were 12 prior reports. They don't look at that. And so you would think they actually should be bringing this into it. And one of the things that I think is most important from Emily Putnam Hornstein's work is that the report to CPS is the single biggest risk for death before the age of 5. It is not whether CPS labels it, but that there actually was a report. So it is interesting that just anecdotally in the child death reviews a lot of the focus is on this very instant, for this specific, and that gun one is a good example. It didn't matter that there was cocaine because in this instance they did not feel that the mother's lack of supervision contributed to the death. But I think the answer is it is very complicated, because nobody is going to sit around the table and say, "Well yes, and..."

Rodriguez: [010-01:40] I was just wondering if anybody had looked for patterns, but it sounds as if it is a context versus no context.

Dr. Berger: [010-01:44] Yes, that's exactly right. And different states actually bring in context differently, in different situations, and actually even within counties where sometimes we have different near fatalities in different counties that we service and we have cases for, even within different counties. Sometimes it is very event-based and sometimes it is very context based. And I don't know that it is intentional, that's just the way that they have traditionally done it in those counties.

Michael Petit: [010-02:20] Thank you, I'm Michael Petit. I had a couple of questions. One is have there been studies done on whether there was earlier or later fatalities in a particular household? I'm familiar with one case in which a mother drowned three children. She was committed to a state institution for 10 years. She came out and had three children and drowned those three children. Is there anything that has been done that just looked at that question?

Dr. Berger: [010-01:44] So we know the data, of course, about parents who have suffocated children. There are single case reports about that. But nobody has looked, as far as I know, at studies of deaths followed by a period of no death, followed by death, which is a really interesting issue. In our system, for example, if something is not counted the first time you're going to expunge it after 16 or 17 months. So if that same person comes back into the system you might not even know that there had been a prior death. Now drowning, those would be included, because people would say that is a filicide. But I think it is very easy for that to happen and us not to know about it because the first one doesn't get indicated, so there is a period of time and the person comes back and does it again. But there is no data that I know of specifically looking at people who hurt, then are in jail for a while, and then hurt again.

Petit: [010-03:31] So related to that question, it is interesting to me that when we measure indicators of a child's well-being, we use it as a rate per 1,000, except when it is child abuse it is per 100,000, which speaks, in the end, to how few deaths there are in relationship to the number of children there are in the culture. But clearly what we're all looking for at some point is what is the particular value of the information that we have? And what is the particular value of the information that we have right now?

Dr. Berger: [010-04:04] That is a really good question. The answer is it is not that good, but you have to understand we don't know. So even in Emily's studies, for example, we say the biggest risk factor is a child maltreatment report, but the vast majority of children who have child maltreatment reports don't die before the age 5, right? So we don't have the data where we can say the predicted value of drug and alcohol use in a parent is "X," and the predictive value of maternal depression is "Y." We don't have that. We only know that there are certain risk factors that appear to be related to death although it also depends sometimes on your data source. So there are different papers showing very different data about even whether drug and alcohol is related, because some of these risk factors are so collinear. Socioeconomic status, maternal depression, other mental health problems, drug and alcohol are all so collinear, and we don't have good enough data to separate out exactly what the predictive value is for something that is so rare, which is why I'm saying actually including your fatalities will help some of that predictive value because you have more children that you can look at. The answer is you'd love to have it, and know if this, and this, and this were there then your risk of death is 80 percent in the next 5 years, but we don't have that data.

Petit: [011-00:19] But there is a point to this, that in terms of the federal government, if all of the cases were put in a single pool, and I'm not saying to the exclusion of them being anyplace else, but if you were take a look at all of them you might have enough of a database to start seeing what might be predictive elements.

Dr. Berger: [011-00:37] And that's a really good point. If we actually had every case of a fatality and whether it is NCANDS or another data set, yes, then you are talking about, actually knew the risk factors and they were measured, you probably do have enough numbers. Because if the GAO would say we have 1,600 that we know then the number is probably 3,000 or 4,000, then we're talking about 3,000 or 4,000, then you are starting to get, unfortunately, numbers that you can actually start looking at. So you are absolutely right, if we were counting well and accurately we, unfortunately, might have enough data to start looking at predictive values.

Dr. Wade Horn: [011-01:11] First of all, thank you for a fascinating presentation, and I am very inclined to agree with your conclusions about measuring everything. My question is this, and it is the interchange with Michael that stimulated it. We often speak as if we are looking for a single predictor. And the reality is that looking for a single predictor is probably not going to get us where we need to be. It is probably more likely that there is clusters of predictors that will give you a better ultimate prediction about what children are most at risk for fatalities. Then, to make it more complicated, it seems to me that it is not just a predictor at a given point in time and whether a child is a fatality, but is there some pattern of behavior that occurs in a sequence? So what research is there in that area and what can you tell us about more multivariant analysis that take a more complicated sort of look at clusters of predictors?

Dr. Berger: [011-02:20] That is a really excellent point, and there is not going to be a single. There is no magic bullet where if a child has this the child is going to die. And so I think the answer is absolutely it is not going to be something simple, and it is not even like as simple as a fingerprint, but something where there is so many aspects that are coming into it and together they probably play together to increase the risk. The answer is no, we don't really have good data on that, and part of this is all the things you are describing are extremely complicated and they are not currently reported. When you sit down for a death review think about all the data that sometimes comes into that, and how much actually comes out on the other side into the NCANDS system. There is so much less that is coming out on the other side. So what is being put into any of these data sets that people have looked at, and NCANDS is the most analyzed of them, the data, even with NCANDS, it says the child died from neglect, but you don't actually know if it is a drowning or a gunshot unless the person puts that data in, you just know it is a neglect death. And you don't know how long the maternal depression has been. Have they had psychiatric hospitalization? The things that we might think of as very, very important, or has there been a prior death in the family, or has a prior child been removed? That data is not all there. So the answer is if the data were there, there are modeling techniques where you could probably start looking at it, but we don't have the data consistently to do it.

Theresa Martha Covington: [011-03:50] Yeah, I have a couple of comments. Thank you so much, Dr. Berger, for your presentation. I really do think it sort of sets us to be thinking about this from a broader perspective. And that, I think, was my comment, is as we think about the data, and you started your presentation, and you were giving definitions, those were really child welfare definitions. And I think it is important, as we think about counting, that we think about what are we counting and for what purpose. So if we are only counting data, for example, for child welfare agencies, to me that gives it a different lens than if we're trying to get a sense of counts from a

public health perspective, or if you even narrow it down if you are trying to count deaths for law enforcement, for example, that changes it completely, because then you are probably just looking at cases where there has been a criminal conviction. So for me it is really important we continue this discussion about counting and that we think and keep clear what we're counting, and for whom, and for what audience, and for what purpose because as we broaden that framework, which I'm a real believer, and I'm totally with you at your last slide, which is we count everything. But if you count everything I think we have to realize we are counting it for a different purpose, maybe, then just counting it for cases that came, for example, to the attention of child welfare with those cases. So I think as we keep this discussion going we really should keep clear in our heads what we are counting, and why we're counting it, and for what audience.

Dr. Berger: [012-00:20] I absolutely agree, and I think philosophically it is interesting that all of this has developed in the NCANDS system, which is a CPS data system, because it implies that when a child dies, for example, CPS did something wrong, right? It somehow puts all the emphasis on one system, and a child death is never one system, there are pediatricians, there is a school, and there are all these systems. And I agree in this much broader sense that it is not limited to CPS, and clearly we wouldn't want to limit to law enforcement. But that is going to be a very narrow group of children, and you can't make policy based on a very narrow group of children. But I think that is the idea of making this much broader and always remembering, as Dr. Gulino is going to talk about, who the data was from. And as we said, CPS, in order to indicate, indication has a consequence and, obviously, criminal conviction has a consequence. There are consequences of labeling in each of these systems.

Covington: [012-01:23] The other comment I had was that in your slide about can we do something similar to maltreatment in terms of being an expert panel? I think for the Commission we really should hear from the work that the Air Force has done because they have created pretty much a field-tested model that led to some real high reliability. And I think maybe at some point we really would want to hear from them.

Dr. David Rubin: [012-01:45] You know, Dr. Berger, I struggle, personally, a little bit with the nationalization of counting in general, partially because I wonder is it feasible. The counting is sort of governed by different state interpretations, etcetera. But also because I think the issue of predictive value. These risk factors, we are talking about poverty, substance abuse. Not everyone who uses drugs kills their children, right, so what is the potential consequence? None of these risk factors, outside of the one mentioned, Commissioner Petit, which is a mother smothers her baby, she is someone who is at risk for killing her next baby, or a parent who kills their child, whether mother or father. Outside of that, I think, to me, the discussion on counting takes us away from what I think is more the germane issue, which is the local organization of interdisciplinary teams from a public health perspective that actually work together to look at all the near-fatal events and preventable deaths, and I think Dr. Gulino will talk about this and how you become responsive as a community from a public health perspective to recognize trends, whether it is a new drug epidemic in your own community, early so that you begin to generate locally-generated responses that can try to reduce the likelihood that some children will slip through the cracks. And so I'm not saying I am against the whole effort and the mobilization around the

county, I just worry to what end, and how does that help? And even if you could do that multivariable analysis, those risk factors are still not going to tell me how to respond in my local community.

Dr. Berger: [012-03:32] I wouldn't want to get rid of a local, because at the local level, for example, there are risks, new drugs, and a whole bunch of new methamphetamine labs. Things happen at a local level that clearly you need to address. So I don't think one is to the exclusion of the other, and a lot of public health campaigns have to be at a local level, and I think that has always been the case. But in terms of the risk factors, absolutely not every time a child is alone in a tub do they drown, and most parents who use drugs, their children don't die. But I think the answer is that we can't because we don't have the numbers, as you were looking at this national data there probably is, as the smothering death, I think we all recognize someone who smothers their child likely to... [inaudible] and the medical child abuse those do tend to recur, and those are very, very dangerous. Parents who physically abuse and kill their child, those are also a very, very high-risk group. But there probably is some combination of prior weapon use, depression, and domestic violence. There probably is some combination that is particularly toxic, plus two children removed previously, or something else. There probably is some combination, because you are right, drug and alcohol is way too broad! But we always talk about this with newborn babies. We screen newborn babies and then we respond in the same way to the babies that are marijuana positive as are cocaine positive. But the answer is probably those are very different babies, but we don't really have great data on how the cocaine baby differs from the marijuana because we call them all drug-positive babies. And so I think that some of what we could get at with larger numbers is looking at the positive predictive value of not just one, but as you looked at, many different things, but also a much more specific look at them, not looking at drugs and alcohol as this big bucket, because that is probably not the risk. And poverty, most people who are poor, aren't going to kill their children, but that may be a risk in combination with unemployment, or lots of other things. So that's, I think, the argument for a much larger data set, but I absolutely agree with you, you always need to have that local.

Dr. Rubin: [013-00:34] Perhaps the middle ground, the focus on near-preventable deaths. Not even so much child maltreatment but deaths or serious injuries that are ruled preventable that have a near fatality component to them is a much larger number and probably gets closer to that intermediate pathway of what leads to death, which is a rare event.

Dr. Berger: [013-00:59] I absolutely agree with you. The idea of the near fatality, we were saying the risk factors for a near fatality are probably very similar to fatality because the difference in the outcome may be a medical intervention as opposed to a risk. So I agree, that is another way. There are kind of two ways to get to big enough numbers where you can start to look at some of these multivaried issues.

Dr. Sanders: [013-01:20] We have three more comments from Commissioners and we'll close off. Commissioner Bevan?

Dr. Cassie Statuto Bevan: [013-01:25] If you are going to use a child-centric paradigm, which I hope that we do use, then don't we have to count every death and

every near death in order to be child-centric? We have to count everyone if that is the paradigm we're going to use. What else would it mean, right? A child-centric paradigm means you count every death or near death. So then what is the tipping point? What would you recommend is this toxic tipping point that would help us get to a place that is, in some way, not overloading the system? We want child brutalities to be taken seriously, so in some sense we need a bigger number, to be taken seriously. A true number, not a made-up number, not an exaggerated number, but a true number. And if it is closer to 3,000 I, for one, would like to know that.

Dr. Berger: [013-02:25] I think you've hit on the real issue, is what is the tipping point? Where is that line in Leventhal's Triangle where we're going to say, "We're going to count everything under that line as abuse." And it's not up to me, but I think it is a panel of people saying, "Where do we want to count it?" And I think what you're saying is, "How do you not overwhelm the system?" I think we have to remember that maybe the answer is the system, being CPS, is not where the issue is, the bigger issue is how many do we have that are potentially preventable. Because I think the answer is if there is no siblings, for example, and a single child dies a co-sleeping death, there probably isn't a role for the system, but that baby still should count because they died. And so I think you are asking the same question that I am, and saying, "We do need an answer, but I don't know where that tipping point is." And I think we don't want to say, "I don't want to count this or this, because it's going to overwhelm a system," which is the argument that maybe it's not the system, maybe we count these independent of the system, which would be overwhelmed by the pure number of them.

Amy Ayoub: [013-03:40] This is for clarification for me. You might have said it so I just need clarification. In order to count in a most effective way would we need to standardize the definitions of abuse and neglect?

Dr. Berger: [013-03:57] I don't think you're ever going to do that because each state, by CAPTA, obviously can have its own definitions. And I don't think the definitions, per se, are the whole issue. I mean I think the issue is like, for example, with Kansas being "clear and convincing." That is so different than other states that maybe you need to say, "You've got to come up to a certain level so you're near the other states." But I don't think you necessarily need to change definitions as much as you need to change the way that people think about why we're doing this. Are we counting because we need a number for child protective services or because we want to look like we're doing a good job? And that goes into certain considerations, whether we want it to or not. Or are we counting because we really just need to know how many there are so we can do something about it? So I don't think we are ever going to change the definition because CAPTA allows every state to have their own definition, but there probably needs to be some... I don't want to say "floor level," but some level where we say, "You've got to agree to this, as per CAPTA, but then you can do your own state-to-state." So I don't think there is an exact answer, but I don't think you are ever going to change the different definitions by state, because that is intrinsic to what CAPTA says.

Hon. Patricia Martin: [014-00:11] So I have two quick points that I'm going to ask you whether or not you would agree with. Since we've been talking this afternoon, we've been talking about the system and defining the system, really, in DCFS or the

state agency. I would encourage us to look at the system more broadly and to include the court, to include the school, to include all the elements that touch the lives of our children in foster care because it's not that the court necessarily, from my bench, can go down and make an investigation necessarily, but the decisions I make certainly can influence what happens outside the courtroom. And the other reason I think it is imperative that we expand our look at what the system is, I think we have to get away from doing things that make us look as if we're accusing the department, because I don't think it is all the department. I think there are some things that the department can do, but I also think there are things that the court can do, and other players on this chain link fence that we call "the system." And would you agree with that statement or do you think that's an appropriate way to approach it?

Dr. Berger: [014-01:22] I absolutely do. And actually, I think that was what I am trying to allude to, but probably didn't say it very clearly. I think that may be one of the problems, is the system, and when I say the word "system" people are thinking CYF. But I say, as a pediatrician, when I say "system" I'm talking about the school, the daycare, the community, everybody that is responsible for that child, because it can't only be CPS. So I think that's really it, when I say "the system" I'm thinking exactly what you're saying, but I think most people would be thinking CYF, because that's the way we traditionally looked at the system. So I absolutely agree with you.

Martin: [014-01:57] So I would think one of the things that I would like this Commission, this body to really discuss is how we are going to look at, and what we are going to call "the system" in our final report. My second comment to get your recommendation about is as we had a conversation about "coke babies," if you will, the whole issue, from the court's perspective when we brought in treatment providers, is they were trying to educate us that it is bad to be a coke baby and their future has some limitations, but we fail and oftentimes overlook the damage that is done by alcohol in-uterus, and we often jump to coke babies and we talk about what a horrible situation, but when we really look at the likelihood of those children at some point making and getting to the 95th percentile, they have a better chance than my babies who are born with alcohol in their system, and yet we all jump to the horrible sexy thing, but we fail to look at the thing that happens oftentimes, and it is overlooked by our "system." And so what I hope that we, as a body, can do is not forget the alcohol babies. Yes, we have to deal with the coke babies, and the meth babies, and I'm not suggesting that they don't deserve our attention, but I also want us to make certain we get to the issues like the alcohol babies, because I want to make certain that we capture those issues. And so when we talk about near fatalities, and the importance of near fatalities I agree with what you have said, but the cases that are not being counted currently as child abuse deaths, I think there is some benefit to making certain we understand those. So even if there are no other children, or infants, or kids under 1 to 5 in that household, yes, I think we should count that child, but I also think it is imperative that we understand the risks that child experienced so we can use that in evaluating the other children that come before us.

Dr. Berger: [014-04:00] I absolutely agree with you, and you made two really important points. Cocaine is a really interesting issue from a research perspective because when the cocaine babies started coming out there was all this, "It is going to be horrible..." and actually the research data is now that if you don't have a stroke in utero many of those children cannot be picked out from their peers by age 5. But we

made a lot of really bad choices, I think, in terms of child protective services intervention based on our idea that the cocaine babies were bad. And I allude here to legal versus illegal, and alcohol is probably the best example of a legal substance where we all go, "It's legal, so it is okay that the parent..." And so I think those are two great examples, because they are kind of the extreme of something that is legal and very common and illegal and not common. But actually the one that is legal is a lot worse in some ways than the one that isn't. So I think it is a great point, and I think that's the reason to count everything, because then you are including all those and you can look at the risks. It took us a long time to realize that the cocaine babies actually look pretty good at age 5, as long as they were in good homes, as long as they were in a stable situation like other children.

Dr. Sanders: [015-00:09] Thank you, Dr. Berger. I'm going to call up Dr. Gulino. I know that Commissioner Petit you have a question, and we will have 50 minutes for Dr. Gulino to present, and we'll have 30 minutes for questions, and I would recognize you first for questions after that.

Dr. Sam Gulino: [015-00:57] Thank you very much, Chairman Sanders, and it's a real honor for me to be here today. It is particularly great to be able to follow Dr. Berger, who is both smart and eloquent whereas I am just a nerd. [laughing] And so what you'll be hearing for the next 45 or 50 minutes is far less eloquent, but hopefully will be informative for you. So I'm the Chief Medical Examiner in the city of Philadelphia, and your first question may be, "Why is a forensic pathologist here talking to the Commission to Eliminate Child Abuse and Neglect Fatalities?" So while I am a forensic pathologist I started my career, while I went to medical school, wanting to be a smart and eloquent pediatrician, like Dr. Berger, and I wanted to help children. And through the twist of fate that we all know happens to people as they go through education, I wound up being a pathologist rather than a pediatrician, and then I wound up being a forensic pathologist rather than a pediatric pathologist, and very quickly I started seeing lots of kids who had died, and I started seeing patterns, and I started getting tired of seeing the same patterns over and over again, which is how I began my career-long involvement in child fatality review, which is how I know Commissioner Covington.

And so it is through that path that I've managed, somehow, having abandoned pediatrics during my medical school career to coming to today where I get to testify to this Commission, and I get to help children. So it is a real pleasure for me to be here.

There is an official number of children who die from child abuse and neglect in the United States every year. And from year to year it varies, somewhere between 1,550 and 1,750 children, according to HHS. And if you look at the numbers, the last for 2012, which is the most recent number, it was 1,640, and over the past five years the number initially went up a little bit, then there was a sharp decline in 2013, and then a gradual climb after that. And these numbers come from NCANDS, the National Child Abuse and Neglect Data System. And as Dr. Berger already talked to about NCANDS, NCANDS has some real challenges when it comes to measuring child abuse and neglect fatalities, among them, that it is a voluntary system. It does report from 50 states plus Washington D.C. and Puerto Rico, but in a given year not all of those may report. Historically, half of the states based their counts solely on child welfare data which, for the reasons Dr. Berger already explained, will undercount data, and undercount

the number of deaths, by definition. The fact that not all children were previously known to child welfare agencies. The fact that not all of them have siblings that require child protection, and the fact that not all child maltreatment deaths result in indicated or substantiated reports, depending upon the specific child protective services laws of the states involved.

A state can report child fatalities to NCANDS in one of two ways, they can report individual cases into what is called the Child File, or they can report an annual guess, an annual estimate into what is called the Agency File. And when I say “guess” I mean guess. I have personally witnessed situations where state agencies have just sat around and looked at the number they thought was correct, and then decided on what number they thought they would report, based upon what they knew in terms of historical underreporting. And so the number that goes in may be a complete fallacy. And then what NCANDS does, when fewer than 52 reporting states, counting 50 states plus D.C. and Puerto Rico report, they take the counts that they are given for the reporting states and they use it to generate an estimate, averaging for population. So they increase it based on the populations of the states that did not report. And so what you have is an estimate based on an estimate, which is really the statistician’s nightmare, and it assumes, when you do that, that fatal child maltreatment is distributed geographically evenly, which of course we know it is not, because things that coexist with fatal child maltreatment, such as poverty, unemployment, social isolation, substance abuse are not necessarily evenly distributed across the population. And so the number that we wind up with really, while it is an estimate, is not an estimate that is based on the same sets of presumptions year-to-year, nor is it even based upon sound statistical principals because of the fact that child maltreatment is not necessarily geographically evenly distributed. And that’s not NCANDS’s fault, this is simply how it works because this is the data that is available.

But we know, as a result of that, first of all the number is too low, and Dr. Berger explained that we know the number is too low because not all of these deaths get classified as child maltreatment by child welfare agencies.

We also know that because of the statistical quirks of the way the number is calculated that these numbers are maybe too high or too low in a given year. We don’t know the direction that they are wrong, is what I’m trying to say. And so while we see a precipitous drop between 2009 and 2010, we don’t know that that actually occurred, in fact the real number may have gone up. And so just the trend may not necessarily be reflected because of the biases that were present.

So the question that came at the end of Dr. Berger’s presentation about why do we worry about measurement in the first place, I think from my standpoint and my perspective as a public health practitioner is that when we are going to look at a way to fix a problem we at least need to know how to measure it to see if the interventions that we used are working. Whether or not we ever get to the position where we can use the data that we have to predict which cases are going to result in child fatalities we at least want to know the number so that we can watch the number climb or decline as we put interventions in place.

So public health surveillance is dependent upon a few very simple concepts. First that you have to carefully define both the thing to be measured and the population in

which you are going to measure it. You have to collect the data and then analyze and interpret it to plan, implement, and evaluate public health practice. And so the specific thing I'm talking about here is evaluating public health practice to know if our interventions are working or not.

The big question is how badly are we undercounting? And the real answer is we don't know the answer to that question. We know that from a study by Patricia Schnitzer in 2008 where we looked at child maltreatment ascertainment in three states—California, Michigan and Rhode Island—the estimate was that child welfare data undercounts fatal child maltreatment by between 55% and 76% of the time. This seems to be particularly true when dealing with issues about neglect, and I'm going to talk about neglect quite a bit in a little while. And when they went back and looked at Michigan data with a specific eye at identifying deaths due to child neglect, which are very often not counted in child welfare data, they identified a 75% increase in fatalities from 110 to 192 over a two-year period. If we were to assume that was the only problem with NCANDS's data, that it undercounts neglect deaths by 75%, then we would be looking at somewhere between 2,700 and 3,000 deaths per year due to child maltreatment. But we know that's not the only factor.

So what data sources can we use when we start to look at fatal child maltreatment? We will certainly immediately go to child welfare data, but in the past there has also been a lot of work looking at death certificate data, FBI Uniform Crime Report data on homicides, and child fatality review data. And each of these has its own challenges when trying to capture child maltreatment fatalities.

Child welfare data captures some, as we've seen, some of the child maltreatment deaths, and in various studies, California, for example, child welfare data missed 76% of their child maltreatment deaths, Michigan 56%, Missouri 21%, and Rhode Island 73%. And that is due to what we've already discussed, what you've already heard today from Dr. Berger, that many times child welfare data will only capture cases in which the child or family have a child welfare history, where there's a sibling who is going to require some type of intervention and, as in Pennsylvania, where a death is only captured as child maltreatment if a perpetrator is identified. There is also a chronic undercount of neglect-related fatalities which, as I said, I will mention more in a bit.

Death certificate data has always been problematic, and I'll talk quite a bit at the end about death certificate data. But in various studies death certificate data has been known to miss up to 90% of fatal child maltreatment cases. The reasons are simple. The first is that people are really not well taught on how to complete death certificates. When I was in medical school we received zero training on how to complete death certificates. And my first experience with a death certificate was after I graduated medical school when I was an intern working in the intensive care unit and I had a patient die, and at 2:00 in the morning the nurse handed me the death certificate and said, "Here, you have to fill this out." And that was my initiation into death certificates, and that is fairly typical.

There are lack of standards in how death certification is done. Some of the fields on death certificates are check boxes, which does work towards standardizing some things, such as whether or not a death is tobacco-related or whether or not a woman is pregnant at the time she dies. But the fields that are used primarily for ascertaining

the presence of child maltreatment are free-text fields, and they have to be coded as child maltreatment based upon computer algorithms at the state level into one of three ICD codes, and that does not happen very often, again for reasons I'll discuss toward the end of my lecture.

Death certificates are not all bad, though. They have two tremendous advantages. The first is that they don't miss a lot of things in terms of the numbers of dead people. Most people who die get a death certificate whereas not all children who die have contact with child welfare, not all children who die have a homicide charge brought on a caretaker who caused their death. So death certificates at least are present, and the question is, is there a way to draw the information out of them better? And over the years some things are actually well-captured by death certificates; motor vehicle crash data, for example, is very well caught by death certificates, and we actually believe the numbers, and believe the trends we see year-to-year from motor vehicle crashes.

Data from the FBI Uniform Crime Reports, again, they tend to miss upwards of 80% to 85% of child maltreatment data, and that is for two reasons. The first is that not all states require reporting of data from every municipality into the FBI Uniform Crime Report system, and many neglect deaths don't lead to criminal charges, for the reasons that Dr. Berger talked about earlier.

Child death review data is an interesting one because it is tremendously variable from state to state. In Michigan, for example, 68% are missed in child death data, but in Rhode Island only 2%, and I'm going to talk a great deal about child death review in a moment, but as a preview child death review is a really promising way to look at child maltreatment fatalities, but it does have its challenges. First, not all states review all child deaths, not all states contribute to the National Case Reporting System, child death review teams have widely varying experience with abuse and knowledge about abuse, and child maltreatment definitions are not applied consistently from team to team.

So what we know is that no one data source has proven accurate over time, but we also know, and this was also demonstrated in Schnitzer's paper in 2008, that case ascertainment can be tremendously enhanced when we use multiple sources of data. And California was an early adopter of this process by which a case would be counted as a child maltreatment death if it was called so by the coroner, by law enforcement, or by child maltreatment. And in fact, when you combine sources of child maltreatment data we find that we can reach a much higher level of ascertainment of the actual number of child maltreatment deaths. So in these various groupings, the bar on the far left is for child welfare, the second is for death certificate data, the third is for Uniform Crime Report data, and the fourth is for child death review data, and then the tallest bar in each group is when you combine data from all those sources to ascertain child maltreatment fatalities.

And the fact that combining various data sources is the best way to capture child maltreatment deaths was, in fact, brought out as a recommendation after the 2011 Government Accountability Office's report and became part of the Child and Family Services Improvement and Innovation Act of 2011, which now requires states that are contributing NCANDS to describe the various sources of data that they use in coming

up with their count of child fatalities and explain why other sources were not used. So it comes short of actually requiring states to use these other sources, but at least it begins the conversation about why states are not using additional sources of information to come up with their counts of fatal child maltreatment.

So the next three slides just look at the relative chance of catching child maltreatment deaths when you use a single data source and when we combine that data source with child death review. So in each case here, child welfare data, when combined with child death review resulted in an increase in child death review ascertainment, the largest one being in Rhode Island, but also California with a tremendous increase in cases ascertained. The same thing happens when you combine Uniform Crime Report data with child death review data, and the same also happens when you combine death certificate data with child death review data.

I want to focus on this last one for the next little bit, because as I said death certificate data, although it is frequently maligned, including by me, is probably the most promising source we have right now of finding missing cases of child maltreatment for the simple reason that every child who dies gets a death certificate almost across the board.

Patricia Schnitzer, a colleague of mine who was one of my coauthors in the child welfare article that I think all the Commissioners were provided with, is currently doing work at the National Center for Health Statistics that I think is really exciting, and I hope that you will have the opportunity, at some point, to present this to the Commission. What she is doing is she is looking at matching child death review and death certificate data from nine states so she has both death certificate data and child death review data from nine states, which required administrative leaps of an unbelievable ability on her part. She is looking at children between one week and four years of age, and all deaths occurring in 2009 and 2010, and she is trying to look at a way to better pull out of death certificate data the child maltreatment deaths, and it is promising at this point. So there are a large number of cases that she is identifying as definite child maltreatment, possible, or probable child maltreatment, based solely on the determination of a child death review team that would not have been found by looking at the death certificate data alone.

I'll admit that I am biased when it comes to child death review because I've been doing it for 20 years and I find that it is a tremendously useful way on the local, county, and state level of identifying ways to improve child welfare in our population. And I am a big proponent of the idea of using child death review as the mechanism for improving our national count of fatal child maltreatment for a few reasons. The first is it has been shown to improve ascertainment. So we know that when you combine other data sources that are imperfect with child death review you start getting better results in terms of ascertainment. Every state currently and Washington D.C. has a child death review process. And so we would be expanding and supporting existing structures rather than trying to create a new one. And also, child death review teams often include people with expertise in child maltreatment, but not always. And it works best when there are either good experts on the team or you have clearly defined parameters about how the team will make its decision regarding whether or not something is child maltreatment.

And so this is where we get to definitions. And so I have a slightly different answer to Commissioner Ayoub's question that she asked at the end of the last talk. And that is that I do think we can create uniform definitions for child maltreatment, but not necessarily for use in the child welfare system or for use in criminal determination as to whether or not someone should be charged with a crime for a child's death. But rather, for the purposes of child death review, so the child death review teams have uniform definitions as they review these cases and can apply them to the cases they review and get a better determination of whether or not a case is child maltreatment, separate from whether or not that case would be called child maltreatment by the child welfare agency, or by the police, or by any other agency.

Physical abuse is usually not the problem, of course. Most agencies and professions agree on the types of acts that we call "physical abuse." There still can be some disagreement, based on agency-specific criteria due to the way state laws are written, but really the problem is in neglect deaths.

Because of agency-specific definitions, including things like religious exemptions, we often have a very hard time distinguishing between what I like to call when I lecture "small-n neglect," and "capital-N neglect" deaths, meaning those things that we accept happen because we are imperfect human beings and those things that happen because they are egregious lapses by caretakers. And when we're trying to make that determination currently there is no consistency because each agency and each investigator will have different views of the societal norms that draws the line between small-n neglect and capital-N neglect. And this is where creating national definitions would be helpful. The CDC already made a go of it in 2008, in fact, because they wanted, for exactly that reason, to have definitions that were not linked to a single agency or profession's definitions. They published definitions to be used, operational definitions that could be used and understood and applied by child death review team members. The problem is that the definitions as regards to neglect still don't go far enough and require a lot more work in order to be operationalized.

So for example, the definition of "inadequate supervision" is "failure by the caretaker to ensure the child engages in safe activities, uses appropriate safety devices, is not exposed to unnecessary hazards, or is supervised by an adequate substitute caregiver." So it includes words that require way too much subjective interpretation, like "safe," "applicable," "unnecessary," "appropriate," and "adequate." We really need better definitions, more specific definitions that will help us to differentiate small-n neglect from capital-N neglect. Then the question is even if we were to sit down and come up with these definitions, even if we were to define what each of these terms means and how they apply to specific situations, how do we get child abuse teams to apply them?

And this is a place where Commissioner Covington stole my thunder a bit when she mentioned the Air Force system. The Air Force has done some work that I think is really, really exciting in this arena. So, two researchers from SUNY Stony Brook, Amy Slep and Rick Heyman, partnered with the Air Force, because the Air Force had a problem around child abuse determinations. When they would have a case of alleged child abuse on an Air Force base the case would be investigated and then the findings would be reviewed by a community maltreatment decision committee who would have to look at all the investigational findings and determine whether or not the case would

be substantiated for child abuse or neglect. The problem was there was tremendous variation in the ways that the regulations were interpreted and so when those cases were reviewed by master reviewers there was not always good agreement between what the community decision boards had come to and what the master reviewers felt the correct answer should be. And so Slep and Heyman developed a computerized system that these community decision boards could use to go through each of the individual parts of a determination to help them break down the decision-making into much smaller pieces. So it breaks down the decision from, "Is this child abuse or not child abuse?" to much smaller questions like, "Did this specific condition exist?" "Did this specific behavior exist?" "Was there a specific outcome?" And based on their answers to each of those smaller questions, this computer system, which is basically just a decision tree, brings them to the decision of whether or not child abuse or neglect occurred. And then when they compared the determinations of these community boards with master reviewers after using this system, they found that there was tremendously good, or at least tremendously better agreement.

So here you have two columns. The first is percent agreement and the second is a statistical measurement called "Cohen's kappa," which basically measures agreement in the way two different groups categorize or stratify cases. I don't personally like the use of Cohen's kappa because it assumes that when the person doing the categorizing doesn't know they will just pick one at random and it doesn't allow for the fact that they are often educated guesses. So I think percent agreement is actually the better measurement here. But it shows that for physical abuse there is a very high rate of agreement, and even for neglect, which has historically been very difficult to get agreement between the way different boards use definitions a very high degree of agreement between community decision-making boards and master reviewers.

And so one potential way to improve fatal child maltreatment counts would take advantage of the existing infrastructure we have in child death review using multiple data sources to identify potential cases of fatal child maltreatment and then using child death review teams to evaluate, categorize, and count these cases of fatal child maltreatment. And that would require two things. The first, as Commissioner Ayoub alluded to, creating agency-independent definitions of fatal child maltreatment that can be applied universally. And then, as Commissioner Covington noted, using a Heyman and Slep-like tool to improve agreement among the teams so that we have better quality of determinations, which will go to a better count ultimately.

So I want to spend the last bit talking about death certificates. It is, after all, one of the things that I spend most of my time on in my professional life, is working with death certificates, and the problems of why death certificate data is such a problem, why it is so bad for many of the things that we want to look at.

So death certificates are intended to serve a very important function. They are intended to standardize recording across the states, and so there is a standard national form, and there is technical assistance available to help people figure out how to fill them out, although most people, most physicians don't take advantage of that.

As I've already mentioned, death certificates have one tremendous advantage, which is that they have to be filed for every death. The compliance rate for actually filing a

death certificate is very high, but incompleteness is a problem. Not all the fields always get filled out, and most states do not aggressively go back to physicians and make them fill out fields that they left blank. But for the two sections that are most important for identifying and categorizing a death as a potential child maltreatment death, completion rates are actually quite high. One is the cause of death field, which actually has to be filled out in every death certificate, and the other is a free-text field called "How Injury Occurred." There is another field that I think lots of people pay attention to called "Manner of Death," and I'll talk about these in a moment, which I am deemphasizing.

But as I mentioned earlier, each state has a computerized algorithm that takes this information that is filled in by the physician who is certifying the death, and assigns it an ICD code, a code describing why this person died. And if what is written on the death certificate manages to get this death certificate coded with one of those three ICD codes it will be coded as a child maltreatment fatality, but it takes a very careful wording to get it into one of those categories, which is why most of these deaths are missed on death certificates.

So who is filling out these death certificates? So on natural deaths, children who are dying in hospitals of diseases like cancer and heart disease, the death certificates are being filled out by their clinical physicians, either their private doctors or the doctors taking care of them while they're in the hospital. But for all violent and suspicious deaths the death certificates are being filled out by medical examiners and coroners. And if you're going to use the death certificate data to count cases of fatal child maltreatment the medical examiners and coroners are going to have to properly investigate and properly certify all these deaths.

So what is the distinction between a medical examiner and a coroner? Medical examiners are medical doctors who are trained in the field of forensic pathology, whereas coroners are not required to be trained in the field of forensic pathology and are, in fact, elected officials rather than appointed officials who need have no prior training in medicine, forensic science, or death investigation. There are some regional variations; there are some states, for example, where coroners are required to be physicians, although they can be any type of physician. There are coroners who are physicians but are family practitioners, for example. The long-time coroner in New Orleans, Louisiana, is an obstetrician, is another example. But generally, this distinction between medical examiners and coroners is accurate.

The type of death investigation system is established by state law. And so a state could have a statewide medical examiner, it could have a regional or country medical examiner system, or there could be individual county coroners. Some states, including the one where I'm from, Pennsylvania, has medical examiners in the large urban centers, in Pittsburgh and Philadelphia, and then coroners in the remainder of the counties. The result is that nationwide about 70% of the death investigation officials in the U.S. are coroner's offices, so these are largely people untrained in forensic medicine. Some states do require coroners to receive basic education, either prior to taking office or via continuing education, but the requirements are inconsistent and they don't always require comprehensive training around child death investigation. And even when coroners do seek training in child death investigation it is entirely theoretical, and it is not being supported by practical experience. About half the

coroners in the country are serving populations of 25,000 people or fewer, which means that a child fatality from abuse or neglect is going to be a rare occurrence, and when the one happens it will be the only one that that coroner will have ever handled during their career.

In jurisdictions with coroners, the coroner almost always has the sole discretion of determining if an autopsy will be done and by whom. A forensic pathologist may be available in some cases for coroners to hire to do autopsies, but they may not always be available or they may be too costly if the coroner has a limited budget. And so autopsies are often done by hospital pathologists without forensic expertise.

The bigger problem is that even when the autopsy is done by a forensic pathologist, someone trained in forensic pathology, the coroner is not bound by the forensic pathologist's opinion, and I've had many experiences in my own career where I've had an opinion that a child died as a result of abuse and the coroner chose to certify the death as either undetermined or an accident.

I put on here a quote from an Indiana state coroner's training board where they say explicitly that coroners can "record a manner of death that is independent and different from the pathologist but any disagreement has to be based on material fact and data not available to the pathologist." In other words, it's fine to ignore what the forensic pathologist said if you didn't give him all the facts. This is essentially the same as going to your doctor and not telling him what all your symptoms are, and then ignoring his diagnosis.

In reality, the autopsy has to be performed with the full knowledge of the circumstances surrounding death so that autopsy findings can be interpreted in context and the pathologist can gather information to answer questions central to the investigation in the same way that the clinical physician has to make their diagnosis based upon all the available information, including symptoms, physical examination, and laboratory findings.

So proper death certificate standardization is barely taught in U.S. medical schools, much less to lay-coroners, and the choice of language is sometimes informed by subjective, or emotional, or even political considerations, since coroners are elected officials. And because of the lack of death certificate standardization, there are a large number of cases that could otherwise be potentially identified as fatalities, child maltreatment deaths, that are not so identified, and I'm just giving a couple of examples here from my own experience.

So the two terms, "cause" and "manner" of death. "Cause of death" means the disease or injury that was incompatible with the child being alive. So it could be a disease, like cancer or heart disease, or it could be something like an infection, as in this example, or it could be an injury, like a head injury. The manner of death is the spot on the death certificate which is a check box. There are five choices, which are natural, accident, suicide, homicide, and undetermined. And then, there is the "How Injury Occurred" field which, when it is a non-natural death, the certifier has to fill in about how the injury happened.

So there was one case, and this happened in my office, the doctor wanted to certify and it came across my desk for approval, as haemophilus influenza pneumonia, which is a particular type of bacterial pneumonia, and the manner of death was listed as natural, because we normally think of infectious deaths as natural, and the “How Injury Occurred” section had been left blank. However, the circumstances of this death were very, very different from what you might expect. This was actually a child who belonged in a family where they did not believe in receiving medical care for religious reasons and this was the second child in this family to die of an infectious disease in five years where the family chose to pray over the child for a prolonged period of time and watch the child die slowly. So based upon those circumstances, this death was instead certified as haemophilus influenza pneumonia, and manner of homicide, and “How Injured Occurred,” caretakers failed to get medical care for the child. Unsurprisingly, the first way would not have been captured as a child maltreatment death, the second way naturally will be. However, one thing that is worth pointing out, and this is why these agencies’ specific definitions are problematic, the second case, even though it was certified as a homicide and captured on the death certificate was prosecuted as a homicide, so it was caught in Uniform Crime Report data, it was not indicated as a child abuse case because there is a religious exemption in Pennsylvania law.

And another example, cause of death, drowning, where the injury was “drowned in a swimming pool,” but the real story was that this was a toddler where the family had a home swimming pool, there was a local law that required complete perimeter fencing around the swimming pool, the family decided not to install perimeter fencing, the child was left unattended in the yard and fell into the pool and drowned. And so in this case, the “How Injury Occurred” section was changed to reflect the actual circumstances under which the child drowned.

In the first situation, this would not be characterized as child maltreatment on the death certificate. In the second situation, I think it depends, and I think this is one place where we have to draw the line as to what we think neglect deaths are. But this case also demonstrates why “Manner of Death” is not helpful, because regardless of whether you think this is neglect or not this is still, under medical legal death certification guidelines, an accidental death. So “Manner of Death” is not helpful in this case in distinguishing between child maltreatment and an accident.

The long-term solutions to this problem of medical examiners and coroners and the effect it has on death certificate data are difficult. So we could say ideally we just transition our coroner systems to medical examiner systems all across the United States and we regulate death investigation by having standards, and medical legal death investigation, and standards of practice for forensic pathologists. The problem is if we were even to try and do that it is going to be very slow and difficult. It would require creation of a model statute, which would have to be adopted by all the states, we would have to expand pathology training programs because we do not have enough forensic pathologists currently practicing in the country to serve all the people in every jurisdiction. So we would have to expand pathology training programs and we would have to increase funding for medical examiner facilities, equipment, staff, and training.

In the short term, however, there are some potential solutions. Development of a nationally standardized child death investigation tool requiring coroners to contract only with forensic pathologists to perform autopsies. Requiring coroners to provide forensic pathologists with all available investigative information, and requiring coroners to defer to forensic pathologists in determining the cause and manner of death would all go a long way toward improving the quality of death certificate data.

Thank you very much.

Dr. Sanders: [022-03:18] Commissioner Petit?

Petit: [022-03:20] My point was to the earlier presentation so I can hold.

Dr. Sanders: [022-03:21] I think Dr. Berger is still here.

Petit: [022-03:22] It was directed more to comments that the fellow Commissioners made. One was with Dr. Rubin talked about the multivariable risk factors. I would just respond to that, and we haven't had any discussion about risk factors, but at some point the weight of a cumulative number of them can make a difference and I wouldn't say that you could stop identifying who's most at risk but you could say, "This pool of people that looks like this gets more attention than a pool of people that looks like this." So more risk factors, you get paid more attention to than not so many risk factors, just in terms of differentiating among those different loads.

And then, the [inaudible] you were introducing was the concept of bias, and race, and all that, which I think is certainly an issue and we're going to have a lot of discussion about that over a period of time, but I just would note, though, that in Maine, when I was the Commissioner of Human Services we did a child death study in which we looked at whether there was a difference in the rate of death by the age of 18 by poor children versus non-poor children. So if you were poor were you more likely to die before the age of 18 than if you were not poor? In Maine, the answer was "Yes, by approximately 300%." We did the same thing in five other states and it was always the same thing. Now the difference by the cause of death varied, but the issue was whether you were poor or not. So poor kids in Michigan, poor white kids, because the differential was three to one again. The differential in Michigan with white kids is they were dying in car accidents and black kids were dying in gun shootings, but they were all dying at the same high rate in comparison to families that were not poor.

So just in terms, David I don't know how you are going to conduct this over the course of our meetings. I mean I don't want to get into back and forth, although I would like to at some point. But those are some of things I had and I didn't want to let it slip while you were still here.

Dr. Sanders: [023-03:25] Commissioner Martin?

Martin: [023-01:32] The only thing I would like to also offer is that when we start talking about risk factors, I think it is imperative that we also match those with protective factors. I don't think we are, at this stage, at liberty to just look at risk factors. That is a skewed impression of what our families look like without including also the protective factors.

And I have one question for the presenter. If I understand correctly the source of education, the difference between the medical examiner and the coroner, my question to you is is there, and I don't mean to insult, I don't have a medical degree and I'm not suggesting that it can be duplicated in other settings, but the talent or the skills that are needed in which to completely fill out a death certificate, or fill out a death certificate more completely, does that necessarily require a medical degree or are there ways in which you can train a non-physician to be able to do it in a consistent way but a better way?

Dr. Gulino: [023-01:33] So I think that the question really has to be split into two parts. The first part is whether or not a case can be investigated and ascertained as being a death due to child maltreatment by someone other than a medical professional who was trained to do that, and the answer is "No." So really we know just from experience that medical examiners that are specifically trained to investigate these cases do a better job at catching cases of child maltreatment and diagnosing them.

In terms of the simple dynamics of filling out the death certificate, like any other skill that can be taught to anyone who has the skill set to understand the components that go into it.

The issue there is it is so restrictive right now about how you fill it out and whether or not that will be caught as a child maltreatment death, which is why either we would have to change simply how death certificates are structured or we would have to change the way in which we are trying to pull that data out of death certificates, which is, as Dr. Schnitzer is working on right now, using child death review data to try and form that data a little better.

Dr. Sanders: [023-02:40:] Commissioner Rubin, then Commissioner Covington.

Dr. Rubin: [023-04:01] Thanks, Dr. Gulino, I thought that was terrific. I think the potential excitement for me in that presentation was your discussion about the Heyman-Slep tool. I think we get caught up because of subjectivity of making a child maltreatment diagnosis or decision. You are never going to get around the tremendous variation in how people are going to interpret that, but at the same time if you disaggregate that into was a parent who was supervising a child impaired or not, and ask for no quality judgment about that, you can imagine a very simple tool that doesn't ask people to render a judgment about the manner of death but allows a much more objective way of measuring whether there were certain elements in a case that increased the likelihood that a case was a child maltreatment by uniform definition. If we could somehow move towards a standardization with very simple rudimentary questions that don't ask for an opinion.

And so yes, I think that is worthy of probably more discussion as we try to talk about standardization rather than thinking about a denominator of child maltreatment.

Dr. Gulino: [023-04:38] I think you are exactly right. The power behind Heyman - Slep's tool is that it removes that necessity of making a judgment, which can be so invested with other potential conflicting factors, including people who maybe are

someone in your community you know. And of course when we are talking about Air Force bases, everyone knows one another. Whether or not a decision is going to be politically charged, or whether or not a decision is going to be emotionally disturbing to someone and removes it down to simple determinations of fact about whether a specific condition for occurrence is present.

Covington: [023-04:39] I have two questions. I noticed in your bio that you are also a professor of epidemiology, so you sort of play a lot with numbers and their importance. So kind of going back to Commissioner Rubin's comment about struggling with the nationalization of data, do you feel that there is value in trying to create a national number and a national baseline of what these deaths really are?

Dr. Gulino: [024-00:03] I think the reality is that people will always want a number. So we can choose not to put importance on it, but it is still going to exist, people are still going to calculate it, and they are still going to report it, because that is what people want. They want to know how many of something happened. If we tell them something is important they want to know why it is important and they want to know how frequently it occurs. So if we are going to have a number I think we ought to have the best number that we can have, and I think we ought to have a number that if we don't believe it is perfect we at least believe it is imperfect for the same reasons every year to the next year so when it goes down we believe that it really goes down, or when it goes up we believe that it really goes up.

We can spend a lot of unnecessary time trying to chase down every last child maltreatment fatality, but at the moment we're not even on the course of trying to make a good, reliable sample of child maltreatment fatalities. We're taking the best data that we have, but we know that it has built-in biases, which is never a good condition to be in.

Covington: [024-01:00] My other question is you talk about, towards the end when you were talking, standardization of death investigation. Are there current standards right now that exist for conducting a high-quality autopsy and a high-quality full death investigation to get to maltreatment?

Dr. Gulino: [024-01:21] No. So the good death investigation and autopsy tools that exist have been developed around the idea of sleep-related deaths, SIDS, co-sleeping, and other sleep-related deaths. There are not good, well-accepted protocols of the same type around identification of child maltreatment deaths. But that doesn't mean they can't be constructed. In fact, they could be constructed using the current sleep-related death protocols as a starting point, because many of these cases come to us originally looking like potential sleep-related deaths and then we learn that they are actually maltreatment deaths.

Dr. Sanders: Commissioner Bevan.

Dr. Bevan: [024-02:05] My question has to do with your short-term measure of a nationally standardized child death investigation tool. Wouldn't that require national death by child maltreatment definitions, which we don't have? I mean wouldn't the investigative tool need to rely on uniform definitions?

Dr. Gulino: [024-02:25] Not necessarily. So the question was whether or not development of a national death investigation tool would require national definitions. And not necessarily because the investigative tool would remain the same regardless of what the ultimate determination was. The investigative tool would simply be a map to the investigator of, “Okay, we start with a case of alleged child maltreatment, here are the things you need to go to in terms of interviews, in terms of scene investigation.” What might change is at the end of that whether that case gets determined to be child maltreatment related or not, but it wouldn’t necessarily alter the content of the tool. I think both are necessary, but it could happen in parallel. They wouldn’t be necessarily dependent on one another.

Dr. Bevan: [024-03:13] Okay, so what do you think about all of the exemptions that is in CAPTA itself. I mean CAPTA does not require parents to act against their own religious beliefs, so there are some exemptions. And certainly the states have a lot of exemptions for spanking, for financial inability, so there are lots of exemptions. What do you think about those in terms of just trying to get to where we want to get to, in terms of counting as much as we can count?

Dr. Gulino: [024-03:45] Right. I think we need to be counting those cases, and that is all the more reason why we need definitions that are divorced from agency-specific definitions, so that state to state, regardless of whether this case would be counted as a child maltreatment case, whether or not this would be prosecuted as a crime, whether or not the medical examiner would call it a homicide, or an accident, or a natural death, the case would still meet the criteria to be counted as a child maltreatment death, regardless of what those outcomes were on the state-by-state level.

Dr. Bevan: [024-04:20] So, we would be recommending that federal law trumps state law?

Dr. Gulino: [024-04:25] Not necessarily.

Dr. Bevan: [024-04:27] I mean we have 31 states that state spanking is allowed. Sixteen states say spanking is allowed, then the federal level trumps that if you want to eliminate that exemption?

Dr. Gulino: [024-04:40] Well, probably not spanking but the religious exemption is the larger one.

Dr. Bevan: [024-04:47] But we are in Texas.

Dr. Gulino: [024-04:48] Okay. And so perhaps it is just a necessity, then, to change the language that we’re using in doing the counting so that the language doesn’t conflict with what is present at the state level. I think there needs to be a clear split between what we are counting, because we believe that as a public health preventable death standpoint these conditions led to the child’s death and were at the hands of a caretaker versus what on a state-by-state level is prosecutable, could be indicated for child maltreatment, or could be called a homicide by the medical examiner or coroner. I think we may just need to create a different lexicon for what we call these deaths.

Dr. Bevan: [025-00:30] We would call them differently at a federal level then at the state level? Two different counts?

Dr. Gulino: [025-00:35] Well, I think they would have to be. I think they very well could be, so that when the states turn in their numbers to NCANDS that would not necessarily be the same number that we're counting, which I think is what we want in the end, because we know that NCANDS is not capturing those cases.

Dr. Sanders: Commissioner Horn then Commissioner Rubin

Dr. Horn: [025-00:50] So we just heard two presentations that basically say the data stinks. (laughing) So I want to know how bad it stinks, because in my judgment the only thing worse than no data is bad data because it leads you to conclusions that may not be true. So when we look at the NCANDS data, and I would be interested in Dr. Berger's point in this as well, how much of the sort of general direction that the data shows can we believe? For example, the data seems to consistently show that more boys are victims of maltreatment and more likely to die from maltreatment. Is that not true? Can we rely on that? How bad is the data?

Dr. Gulino: [025-01:52] Well, I think that was my point on one of the first slides. We don't know the answer to that. NCANDS data is what we have, but we know that it is inherently biased, but it is all we have. And so what we're talking about today is really creating something else that does the job of what we really want to do, which is to really count child maltreatment deaths. I think one thing that you said, though, which on a basic level I don't disagree with, is that the data stinks. May or may not be true. The reality is that these kids did die, and there is information on them. It's just at this point we haven't found a way to easily glean it or to easily find these cases, which is why Schnitzer's work with the NCHS is so interesting to me because if there is a way to take existing death certificate data and pull more information out of it using child death review, that would mean the data doesn't stink quite as bad as we think it does. So each time we go back and we re-look at this data by combining and using different data sets and matching, like Schnitzer is doing currently, we give the data another chance. And until we set up a national system where we can get a more consistent count that is really the best we can do, is going back to the data and seeing if there are ways to make it stink less.

Dr. Rubin: [025-03:13] I'm trying to wrap my head around both Dr. Berger's and Dr. Gulino's presentations. And I'm struck by Dr. Berger, by what you said, which is, "We have to treat this separately." I mean the fact that we're talking about this belonging to NCANDS, which is a child abuse and neglect data reporting system, what we're talking about is a national death registry for children that is independent from the investigation on the CAPTA side. The Heyman-Slep tool is great because it asks fundamental questions that would classify deaths of children on the basis of characteristics of those deaths, not asking someone to render an opinion. And only if you kind of create that sort of stand-alone death registry are you really going to have a denominator that you can fundamentally believe, and that really sort of side-steps state law, because it doesn't ask anyone to render an opinion about the manner of death.

Dr. Gulino: [025-04:3] And that database already sort of exists with the national database from the National Center for Child Death Review. It is just that the infrastructure that is currently in place with how the different death review teams work state to state don't really let that currently be a reliable place to get the number from. But it could!

Petit: [025-04:31] In 1987, Congress passed a bill that would set up a national Commission on all deaths of children, including the creation of a registry. It never was implemented for lack of appropriations to fund the bill, but the bill is actually written and adopted by Congress. The question that I have on the medical issue that you raised, in terms of [inaudible] diabetes. When I was a Commissioner we would case line the situations where children had diabetes and the parent refused to provide the child with insulin, which meant the child was going to die. Is there any state where that would trump the religious choices of the parents and would not be trumped by the state child protective services law?

Dr. Gulino: [026:00:21] Unless the parent has been court-ordered to administer insulin to the child I don't believe there is any state where that situation would trump the religious exemption.

Petit: [026:00:30] Is there any state where they wouldn't interject themselves into being in that situation?

Dr. Gulino: [026:00:36] Well, I think those are really two different questions. So in Pennsylvania, for example, when we had this family where we had a second death of a child due to an infectious disease, despite the fact the child welfare agency could not indicate the parents as being perpetrators of child abuse and neglect they were still able to go in to get a court to order the children, the other remaining children, have medical evaluations to make sure that they were not at risk. And ultimately those parents were both charged with 3rd-degree murder and were convicted. And so I think once again we're kind of separating what the law says in terms of what the ultimate determination must be from what the interventions can be and how we count that death.

Dr. Horn: [026:01:16] Yes, so as I recall, the exemption is not to allow the parent to deny medical treatment. The exemption is that the parent is excused from culpability or from guilt, if you will, if something bad happened to the child, but the state always has the authority to intervene in a case where a child's health is at risk when a parent is withholding medical treatment. That's my understanding of the law.

Martin: [026:01:50] Although you've repeatedly stated to us that there is not an easy fix, both speakers have said that, if I understand correctly the difficulty of relying on the death review registry is that death reviews around the country differ on how they convene their work, and do their work, and carry out their work. And I would attest that I would agree with that statement, they are very different. In fact, the death review I sat on wanted to reform the hot dog industry about who could eat hot dogs and how, so I'm sure there are differences. But the point is, and my question is, is there a way to then go back and try to standardize or work with that entity to standardize or more objectively make their decisions or help them come to their

decisions so that number that they have for this national registry becomes more reliable?

Dr. Gulino: [026:02:47] I think there is and I think the reason I can say confidently that there is is that the people who sit on child death reviews are generally very much in favor of doing all they can to identify and reduce numbers of child fatalities. So I don't think there will be any resistance from the child death review culture, per se, but I think it requires changes on two levels. The first is that it will require that states that don't currently require examination or review of all deaths would change their statutes to require a review of all deaths or at least of all deaths due to suspected maltreatment. The other is that in order to get teams which are going to have very different compositions from county to county and state to state on the same page with regard to their determinations you would need a tool like the one developed by Heyman and Slep so that those decisions are broken down into small, bite-sized decisions for the teams to come to rather than an overall decision of whether or not maltreatment is present.

Dr. Sanders: Commissioner Zimmerman

Zimmerman: [026:03:53] I don't really have a question more of a statement. In thinking about child death reviews and how those occur, I know working with sovereign nations, tribal nations across the United States there is always an issue, and this is probably the policy side of it, around funding. For example, working with a particular tribe where they experience a cluster of suicides, and on all deaths we assume unattended deaths have autopsies performed. And for this tribe, the tribe is the one that paid for the autopsies, and so those did not occur. So technically, we really are going on the hearsay or the description of the family saying how they found the child. We don't really have an investigation. The coroner was a local county sheriff's deputy who was assigned to be the coroner, who had a high school education. So there was no investigation, there was a hearsay about how it was done, and the tribe couldn't afford to send the child for an autopsy in order to find out if indeed it was a death by suicide or homicide. We just don't know. So I guess my statement is when we're thinking about child reviews or how we do this in this country, it really has to come out of a policy issue as to who is going to pay for it because those sorts of questions we might be assuming states pay for them, or if this is what occurs quite naturally in all of our communities, particularly if they are urban and they don't.

Dr. Sanders: Commissioner Rodriguez.

Rodriguez: [027:00:30] You know, I think I'm still actually kind of stuck in grappling with both of the questions, and part of the reason is because when you were talking about that our culture has changed, like we used to carry babies on our seats instead of in car seats, and we used to have babies sleeping on their bellies, I don't think I agree that there is sort of uniform culture around the way that we care for children. I'm just thinking I know neighborhoods, even now, where having a 6-year-old babysit other children, that that is acceptable, or where people have completely different value systems about guns in the household. And I'm not putting any value judgment either way, but it seems really complex to me. The complexity only disturbs me in terms of thinking about predictive value of data that we gather and trying to figure out why is what is happening, happening, and what is the intervention that is actually

going to stop and protect the child? It seems like it is not simple, and I was sort of expecting there to be a simple answer from this, and the more I'm hearing the more I'm realizing, no, it's actually really, really complicated. I personally really don't care about data unless it allows you to develop an intervention that is going to fix it, otherwise I actually feel like we might be better off just not having data at all, because people develop interventions that don't ever get at the problem, and they fund a lot of various people's professions, but they don't ever protect kids.

So I guess my question is has thought been given to (1) who you have to have on a child death review team to make sense of all the cultural factors that are involved with any given situation so that you can identify what is really happening here and what is the intervention that is going to get at this. And then (2) is if we did have some sort of a national data registry, or the one that we already have, is what we're collecting, is it adequate to get at the level of sophistication that is needed in the analysis?

Dr. Gulino: [027:02:54] So in response to your first statement, you are confused because it is confusing, and I get confused as well when I look at this stuff because it is difficult to dissect where we should be going next with it, and it is difficult to know how much we should put into something in resources when we try to decide whether or not it is going to give us some meaningful information in the end that we can actually effect some change with.

With regard to child death review, the power of child death review, when it is done on a local level, is that it is made up by people in the community where the deaths occur. And so the team automatically provides context, and there are guidelines around who should be included in child death review teams, so it is not just physicians and law enforcement, it is also community agencies, and it is advocates, and it is people who are in the community and can provide context to what is going on in terms of specific neighborhoods or specific cultural populations. And I think you're right on point with what you're saying about having to have this kind of cultural sensitivity, whether it is based on ethnicity or based simply on neighborhoods, or on families, or religion. Because for example, when we're dealing with the difficult issue of co-sleeping, this is one place where I tend to part ways with many of my colleagues and pediatricians, which is that co-sleeping, although it is often talked about as a neglectful situation, because you're putting a child in a risky position, is not, by definition, certainly not illegal, and it is considered culturally not only acceptable but absolutely necessary in many cultures. And even now parents are getting conflicting information, where they may be being told by their pediatrician that they shouldn't co-sleep but the nurse who sends them home from the well-baby nursery, who has been there for 30 years, says, "If your baby doesn't like sleeping on his back you might try on his stomach." And when they get all this information from their health care providers they get home, and their aunt or grandmother says, "You better sleep with that baby because that is what you do." And I can tell you from personal experience, we have a large Vietnamese and Cambodian population in Philadelphia and what I do not see are any Vietnamese or Cambodian babies who die during co-sleeping. We just don't see any of them! They just don't happen. And so one of the things that we need to do in coming up with these definitions is consider whether or not we are being culturally biased in the way we're making these definitions, because what we may be thinking of as the simple risk factors, such as co-sleeping, is probably much more complicated. And why is it that

with poor black families in north Philadelphia co-sleeping is a serious risk factor, but poor Cambodian families in northeast Philadelphia, it's not.

Dr. Sanders: Commissioner Bevan

Dr. Bevan: [028:00:33] I'm trying to still reconcile what you said in your paper about death investigations and determinations in terms of maltreatment are "decidedly a local matter." And then you are calling for a national death registry. Wouldn't the national death registry rely on the decidedly local matter of child investigation and determinations?

Dr. Gulino: [028:01:05] So it would certainly rely on how the death investigations are done and what the ultimate determinations are, but it would not necessarily rely on whether or not there was a child welfare determination of child abuse and neglect or whether or not there was a law enforcement finding and criminal charges.

You are absolutely right. So what was meant by that is that currently each state decides on its own how deaths get investigated, whether it is by a lay-coroner or an appointed medical examiner. And if that is going to remain then we need to make sure that these cases are being investigated properly, either by changing the systems or by making sure the coroners are better equipped to do these investigations so that the data going into a national registry will be more reliable.

Dr. Sanders: [028:01:55] Dr. Gulino, I had a question and it looks like it might be the last one. Congress, in putting together the Protect Our Kids Act, found an undercount that NCANDS was an undercount of child fatality, and both you and Dr. Berger have suggested that. What I'm less clear about, because it sounds like from some of the things you said that in fact there are some pieces on NCANDS that might be an overcount, and that it is more "we don't actually know." And I wonder, is there, of the 1,700 deaths, a number that we can feel confident with?

Dr. Gulino: [028:02:38] So I don't have a number that I'm confident about. And I think the bigger problem is not simply the undercount, because undercounting is fine if you are undercounting the same way all the time, because then at least you have a trend year-to-year to look at and you know what the change is and whether it is going up or down. The issue really is that the factors that go into the count each year change, which states do or don't report, how they come to their numbers, whether they report a single number in the Agency File or report individual cases in the Child File. Those change year-to-year, and so the reason why we're undercounting changes year-to-year, that is the biggest problem. So while the undercount, I think, is important and it would be better to capture more cases simply because that will give us a fuller idea of the scope of the problem, the bigger problem with regard to understanding trends is simply the change in bias year-to-year about which cases are being counted and which are not.

Dr. Sanders: [028:03:45] Thank you very much, for taking the time and thank you Dr. Berger. Dr. Teasley is here, and maybe we can have you do the welcome before our break.

Dr. Teasley: [028:04:00] Well, thank you so much. It is good to be here before you, and welcome to the College of Public Policy. I think we are about two hours into the Commission's hearing today. If you look at my bio that I sent in to the Commission, I am not necessarily a child welfare expert. My research is basically on children in schools. In fact, I am the editor of a journal, *Children in Schools*, and most of my research is around the socialization of children and how schools impact that. I just want to advocate for one thing here today, and that is that throughout the nation child welfare is changing very swiftly, particularly as we have increasing fiscal austerity, and ballooning wealth gaps, for whatever reason. There are growing numbers of children in poverty among minority populations. I think some 30% of African-American children are now in poverty, about 25% of our Hispanic brothers and sisters, and there's about 15% to 17% across the board. And so I heard this first speaker, and I think Dr. Berger talked about a much more child-centered society. And I teach a course on social welfare policy, and what I do is set up a set of dynamics for students to kind of walk them down the trail where we are asking people to work more because we had welfare reform in the 1990s, and people are working more for less and receiving less benefits. And while women and men are working more the point is what is happening to our children? And so there needs to be somewhat of a cultural shift in our society that is much more child-focused and child-centered. In the state of Texas, about 26% of the state's young people live below the poverty line. In the U.S. about \$500 billion a year is spent on educational outcomes and on child poverty, and in Texas alone about \$60 billion a year is spent. And according to the Annie E. Casey Foundation, only nine states have a higher child welfare poverty rate than the state of Texas. All of them happen to be in the south, for whatever reason that is I don't know.

Many of the children that are suspended from schools that get into fights, that are bullied, that are seen for truant behavior themselves have experienced high levels of trauma. And trauma exposure dramatically increases the likelihood of children developing antisocial outcomes, such as substance abuse, truancy, bullying, etc. And I want to put a plug in for a growing body of research called trauma-informed care. And that is the notion of assessing children when they come into our various agencies and state agencies so we understand have they been impacted by trauma? Children who experience high levels of trauma lack self-control, they are much more anxious, they do less well in school, and they are much more likely to engage, as I said, in antisocial outcomes. Children that grow up in chaotic homes where parents have intimate partner violence, and we know that intimate partner violence increases when there are fiscal concerns in a capitalistic society. Those children are more likely to experience trauma.

And so what we know from research is that a lot of children in our foster care system, within the child welfare systems have experienced copious amounts of trauma, but we're treating them and intervening them for all other things that we see them for, and so I just want to put a plug in for House Bill 1143 that didn't pass this last legislative session. And it is a bill that will state that all children coming into our foster care system will receive trauma-informed intervention. That is, they will be assessed within their first 45 days of being received by a clinician who will give them a trauma-informed assessment as well as a psycho-social assessment, and that the clinician will not only visit with that child and the parents but will talk to people within the communities where those children come from.

I think that will help us a lot. And while we don't know if that may reduce the cost, it may. And so in many cases I think we further do damage, or to put it milder, harm to our children and youth when we have incomplete information in terms of assessing them. Therefore, trauma-informed intervention may help point us in the right direction concerning the underlying problems that may not be evident when children are present and come before us.

And so again, while I'm not a politician or I don't have any stake in this fight, I would advocate for the Commission to encourage and to promote House Bill 1143. Thank you.

Dr. Sanders: [030:00:01] We are happy to be in your facility and we are at the time of a break now. We will break until 3:40 and reconvene with our Practice in Texas panel.

[Break]

Dr. Sanders: [031:00:01] So we have quite an afternoon of speakers to help us understand the work in Texas, and we've asked speakers to focus on how does Texas count fatalities, what works and what doesn't, what the federal government can do, and perspectives they have on confidentiality. There is a lot of work going on here in Texas that we'll have a chance to hear about, and each of the speakers has either provided or had the opportunity to provide written testimony in addition to their oral testimony. And because we have so much to learn we do have, as you will note, a number of speakers and we also want for each of the speakers to have time for the Commissioners to ask questions. So we're going to adhere strictly to timelines and I will mention the anticipated time for each of the speakers, and we'll make sure that we also have time for Commissioners to ask questions after each of the presentations. We want to make sure we get to everybody so I don't want to be rude but I might have to cut people off if we get longer than the stated time.

We are going to start with State Senator Carlos Uresti.

Uresti: [031:01:51] Good afternoon, everyone. I want to welcome the Commission to San Antonio. I was talking to the Chairman a minute ago and of course we're very proud of our Spurs here in San Antonio. He is from Seattle, and his comment was, "Well you already have four rings." But you see, our pinky ring is lonely, so we need five rings and then we'll be happy. But I want to welcome all of you, again, to San Antonio. It's a lovely city, it's a beautiful city and we have so many wonderful things to offer here in our town, so I hope you have a chance to enjoy it.

A little bit about my District. I represent District 19. It is the third largest District geographically in the state of Texas. I represent approximately 800,000 people here from San Antonio to Ft. Stockton, Alpine, which is West Texas, if you will. It is about 400 miles from here, and then south I go to Crystal City and Carrizo Springs. So I represent about 17 counties, about 35,000 square miles. There are 31 Texas senators. All of us represent about the same amount of people, although my colleague, Senator Van De Putte's district is just the inner part of San Antonio. So geographically they are not the same, but population-wise they are. Of course, the demographics are different, depending on what part of Texas you are in, so having said that, there are unique challenges. I think, that face each district as well. I have served in the Texas

senate going on 9 years, and prior to that I served as a state representative for about 8 years.

And during my 17 years in the legislature I've had the chance to work on public health and human services throughout my legislative career. At one point I was the Chairman of the Human Services Committee several years ago, and currently I sit on the Senate Health and Human Services Committee. And we've had a chance to do some wonderful work here in the state of Texas.

Let me give you a few statistics. Last year in Texas 156 children lost their lives to abuse or neglect, and over 66,000 were victims of abuse or neglect. And think about that. 66,000.

So for those of you that are familiar with San Antonio or with our facilities, we have the AT&T Center, which is where the Spurs play, and we have the Alamo Dome where they used to play. And to give you an example, the indoor arena where the San Antonio Spurs play is about 20,000 folks. So you could fit three times that many children that were victims of abuse and neglect in the AT&T Center. Think about that, 66,000 kids.

Also, I would like for the Commission and the folks here this afternoon to consider these statistics. Child abuse victims are 6 times more likely to commit suicide, 24 times more likely to commit sexual assaults, 6 times more likely to abuse their own children, 25% more likely to experience teen pregnancy, 25% more likely to abuse drugs or alcohol, 59% more likely to be arrested as a juvenile, 28% more likely to be arrested as an adult, and 30% more likely to commit a violent crime. So to put it simply, this affects all of us.

So how did we get there? It is important to understand how child abuse and neglect fatalities are counted, and I understand that the committee has a tremendous amount of experience, but I do want to go through it just briefly as to how that works.

Texas law says anyone who thinks a child or person 65 years or older is abused or neglected must report it to the Texas Department of Family and Protective Services, DFPS. A person who reports abuse in good faith is immune from civil or criminal liability. A CPS investigator then gathers that evidence to determine whether the allegation can be substantiated, and if a preponderance of the evidence shows that it can be then the case is designated "reason to believe."

Cases deemed "reason to believe" or what we determine to be instances of abuse or neglect in Texas, again 66,000 victims of abuse and neglect that were confirmed. So what that tells you is there were a tremendous number of children whose cases just weren't confirmed for different reasons. They just couldn't quite put their finger on who the perpetrator was, for example. So I realize that the Commission's focus may be more narrowly tailored to address prevention and elimination of child death, and I applaud your efforts. But it is important to note that while CPS investigates all abuse and neglect fatalities, the department has initiated a more rigorous statistical and data-driven analysis of those deaths in an attempt to identify trends that might then be used to aid in prevention, which brings me to the topic of what I believe works, and that is prevention in one word.

Many of you are familiar with TexProtects, which is run by a good friend of mine, Madeline McClure. If you know TexProtects you know that they strongly support and nourish family partnership as a prevention program. And I'm not going to steal her thunder, but it is one of those program that we know works. According to the Rand Corporation and the Washington State Institute for Public Policy, proven home visitation programs have estimated returns of \$1.18 all the way up to \$14.65 for every dollar invested in the program. As Casey Family Programs recommends in their March 2014 report on home visitation, we need to better understand the costs of these programs compared to the benefits based on how they are implemented, including the size of each program. And we can learn from each other and produce the maximum benefit both for our families and for our government.

With regard to wraparound services, in 2013, I authored a bill, Senate Bill 769, which established a pilot program right here in Bexar County that at this very moment is providing specialized training with families with severely traumatized or special needs foster children, taking full advantage of these wraparound services. Those families will be empowered and enabled to better care for the foster children that they have selflessly accepted into their loving homes.

What else works for prevention? Again, to put it briefly, advocacy. Advocacy works, such as this federal Commission, the statewide and Bexar County Blue Ribbon Task Force, which we created 10 years ago locally in San Antonio, and then expanded it in 2009 to a statewide task force.

What doesn't work? Indiscriminately slashing investment in prevention. For over a decade we have invested less and less into prevention, although the department is doing a wonderful job under the leadership of Commissioner Specia, a dear friend of mine and co-founder of the Blue Ribbon Task Force. As a legislature we need to do a better job when it comes to funding. Approximately 5% of the total budget for DFPS is spent on prevention and the remainder after the fact. So it is great that we're doing that after the fact, but we need to do a better job beforehand.

I see that my time is about up. I want to thank the Commission again for your work. I will offer my assistance and the assistance of my staff as you move forward, should you need it, should you have any questions. Again, thank you for the work that you're doing and Mr. Chairman, I will be happy to yield and answer any questions you may have.

Dr. Sanders: Commissioner Petit

Petit: [033:00:56] Thank you very much, Senator. You began your comments by saying there were 156 homicides, I think, last year. The year previously, I think, there were 250. It shows a decline of 44% from one year to the next. Do you believe that is what happened? And if so, how did it happen.

Uresti: [033:01:10] The year before I think it was about 229. It is a dramatic decrease that everybody is excited about! I would like to say that it is because of the awareness that we have done locally and throughout the state, which I think has been a tremendous effort over the last several years. Too, because of the different

prevention programs that do exist. There are so many different advocacy groups, Commissioner, that I see represented in this room, not only in Bexar County but throughout Texas, that are doing a better job as well. And I hope that next year, if you all come back to San Antonio, we can talk about another 25% decrease in that number. But to be able to point our finger, or put finger on one specific reason, I can't do that. I don't know if the Commissioner can, but I think generally speaking it is because of the effort that we have done as a state and as a community that has helped to get to that point.

Dr. Sanders: [033:02:17] Thank you very much, Senator. If Commissioners have other questions I believe we can send you something in writing?

Uresti: [033:02:21] Yes sir, absolutely. Thank you very much.

Dr. Sanders: [033:02:30] We have Commissioner John Specia, and he will give us an overview of work in Texas and we'll have about 15 minutes for his presentation and then 5 minutes for questions.

Commissioner Specia: [033:02:45] The number was 212. I just got corrected by one of my staff, and it is 156 last year. Good afternoon, Chairman Sanders and members of the Commission. My name is John Specia, I'm Commissioner of the Department of Family and Protective Services. I've been Commissioner about a year and a half. Prior to that, I was the District Court Judge here in Bexar County for 18½ years. I supervise all the child abuse and neglect cases here in Bexar County. I served on the board of the National Council of Juvenile and Family Court Judges with Judge Martin. I'm going to be jumping around a little bit because people have hit some of the stuff I've already gone over.

I would be remiss in not recognizing Senator Uresti. I have known him since he started as a House member 17 years ago. Very shortly after he was elected, we sat down and talked about child abuse and neglect, and he has been one of the great champions of child abuse and neglect legislation for the last 17 years. We have a representative, Donna Duke, who was going to testify today, but she is not going to be able to, but she is a supporter. Some of her staff is here. And the Speaker of the House, Joe Strauss, is from Bexar County, and he has been greatly supportive of my agency. In the last session of the legislature they gave me almost 300 million more dollars and increased my staff by about 1,000. So the legislature has been responsive here in Texas. And Congressman Doggett, formerly on our Supreme Court, I don't know if he is coming or not, but he has been a great advocate.

I'm glad you selected San Antonio. It is home turf for me. You are coming to a community that has recognized the issues of child abuse and neglect. I co-chaired the Blue Ribbon Task Force with Senator Uresti. This community comes together regularly to look at what we can do better. We are focusing on a public health approach and a collaborative approach. We have many different prevention and intervention services here in Bexar County focusing on the needs of families who are involved with child protective services and are struggling to keep their kids safe. We currently, in Bexar County, have launched a "Be on the Lookout" campaign. One of my workers is going to testify briefly, but as a public service prevention effort focusing on safe sleep, drowning, and hot cars with posters all over this city.

We struggle with how to best address child fatalities due to abuse and neglect, but we have a number of initiatives underway in this state. I have been focusing on safety since the first day I took this job. I wanted to make sure that when a child dies of abuse or neglect we have a strong and objective review process in place to look at the circumstances of the case. I ordered an audit of our child death review process. We got the return on the audit and we've completely revamped how we look at child abuse and neglect fatalities in order to capture the data, roll it up, and look at what we can do differently.

At the Department of Family and Protective Services we fulfill our mission through a number of different things. Texas is a state-based child welfare system. So all of the workers that work for me out of about 8,000 people in child protective services, but we also are part of an enterprise, our Health and Human Service Commission that has the Department of State Health Services, and we try to focus all of our resources on child safety, permanency, and well-being.

Senator Uresti talked about prevention, and I'm a major fan of prevention, and we've gotten some additional resources in the last session of the legislature, but we are a reactive agency. We react to a report that a child has been abused or neglected. We need to have other things going on in the community that prevent child abuse and neglect.

Here in Texas, we have a statewide intake system. I have about 400 people that operate 24 hours of the day, 365 days a year. It handles all the calls of abuse and neglect both of children, the elderly, and the disabled. We also have a Texas Youth Runaway Hotline which allows teens to call in, text, go online to chat with trained volunteers who offer crisis counseling and referrals for troubled families.

To put it in perspective, our statewide intake took in more than 730,000 calls last year. Of these, more than 229,000 met the statutory definition of abuse or neglect and were sent to child protective services for investigation. In addition to supervising child protective services, I supervise the child care licensing programs, which regulate all child care and child placing agencies in the state. Unlike other states, all of our licensing information is available to the public, and you can go to TexasChildCareSearch.org and you can look at the regulatory records of any facility that is regulated.

One of my biggest concerns is child safety and illegal child care operations. Many of the safe sleeping deaths and deaths are in those kind of operations. We have more than doubled, and for the first time we have specialized investigators going out and aggressively trying to find illegal child care operations. If they are subject to licensure we will license them, and it's more technical assistance, getting the background checks and so forth, but if they are people that shouldn't be providing licensed care we will shut them down.

Parents are attracted to illegal care; it is cheaper, but the dangers are incredible. Sometimes the staff ratio is 1 to 44. Very unsafe sleep practices and all kinds of bad things. Unsupervised pools if you do it in an apartment center. So we need to focus, if

we are going to reduce child fatalities, on the child care licensing side. We have over a million children in regulated child care in the state of Texas.

We have 27 million people in the state of Texas and 254 counties. Harris County, a million children. The most standard metropolitan statistical areas in the nation, but I also say we have a whole lot of counties with more jack rabbits than people, so providing services in this state is a very complex endeavor. To put it in perspective, the child population of Texas exceeds the entire state population of Tennessee. We increased by a million children in the last 10 years. We are also a mandated reporter of suspected child abuse and neglect. Our definition of child abuse and neglect is very broad. All deaths of children under the age of six must be reported to the county medical examiner. All child fatalities where abuse or neglect is suspected must be investigated, and being a state-run system we have one set of standards and policies that applies to all investigations. We report all confirmed abuse and neglect-related fatalities, while other states do not report all of them, and Dr. Berger talked about that. Montana only reports child deaths when the children were in conservatorship. Some of the states wait until their child fatality review team finishes their review before they do the reporting. I think that we broadly report.

Every child abuse and neglect fatality represents an immeasurable loss to the family and to the community, and is devastating to my workers and every health care person, every family member involved. We mourn the death of each child, but I want to learn from those deaths! I think we have an obligation to learn from those deaths. And so in the past fiscal year our numbers have been dropping. How confident I am with those numbers...I have made them assure me that we are counting exactly the same way, so I believe that the numbers were captured the same way. Whether we're capturing all the data, I'm not sure, but we are working with our Department of State Health Services to do matches with death certificates, so we may be on the end of reporting more child fatalities.

We can't say why the numbers are dropping. We hope that is because of community awareness and the efforts by the state, and the nonprofits. You are going to hear from a lot of them today. A lot of community information is being provided to communities and many, many entities in the state are working on this program. From the people testifying you've got law enforcement, nonprofits, and policy makers. We are all focused on this effort.

I was a District Court judge for many, many years. When I became Commissioner I think that I thought most child abuse and neglect fatalities were blunt force trauma and I was completely wrong. Eighty-one percent of the children who die in Texas were 3 years old or younger, and 50% were male. The majority of confirmed fatalities, 59%, were due to some form of neglect rather than abuse; lack of medical care, firearm safety, drownings and all those kinds of things. In the majority of the cases of the 156, 89 of those fatalities were not known to the department, there had never been a referral. So the majority of the child deaths that we count were not reported to the department. One of the things we include as a child abuse death would be if the parent was under the influence and was driving and the child was killed, that would be a child abuse and neglect death. The same thing with safe sleeping, if the parents are under the influence it is much more likely to be found to be an abuse/neglect death.

In the past 4 years, the number of intentional physical abuse fatalities has dropped by about 30%. So we are looking at the data, the data is important, we've changed our system of collecting data, and we're trying to make sure it is collected the same way across the state. We have dedicated staff that is looking at the data and reporting the data, and trying to help us do the right thing.

After reviewing the fatalities in 2013, we found that the lack of protective capacity of the caregivers is the major factor in child fatalities. In order to provide more protection for children under 3 and those children that we have conservatorship of or that we directly affect, we are increasing the number of safety checks and unannounced visits for children in foster care and kinship care. When we perform safety checks we look for safety threats such as swimming pools that are not fenced, firearms that are not properly protected, and we also look at family violence issues. We need to be much more sensitive to family violence in the context of the kinship family or foster family. We are working with that, we have a pilot going here in Bexar County. We are working very, very closely with the family violence providers to staff and coordinate on our child abuse and neglect cases that involve family violence.

We have an internal process that kicks in immediately with real-time review of the abuse and neglect death. We have started a new project called Project Hit, and we are providing preventive services to families who have previously had their parental rights terminated due to child abuse and neglect who currently have a newborn, families whose child died from child abuse and neglect and who have a newborn, and current foster children who are pregnant or have given birth in the last 4 years. It's a prevention approach. We are trying to get services out to these families to prevent a tragedy.

We support the work of the Commission to reduce fatalities. You asked me what I think you could do to help us. I think keeping consistent data across jurisdictions is important. It is dramatically different, and my good friend, Chairman Sanders, can say, "We're number two in the states." I'd like to have the data collected equally to say that. I would like Congress to look at giving us some flexibility in federal funding. We need more funding for prevention to avoid child abuse and neglect and we need more funding in our federal dollars so we can address the problems at the front end and not the back end.

It is only through a universal commitment that we can reduce child abuse and neglect deaths. I am very concerned about the near deaths. That is a matter of luck a lot of times and we need to be talking not only in terms of fatalities but serious injuries and looking at strategies. I am very interested in predictive analytics if we can get good predictive factors to help us identify families that need help and make the right intervention! We should never take a child into foster care if it doesn't need to go into foster care, but at the same time we shouldn't be leaving children in danger because we missed it.

So thank you very much for the opportunity to present. We will supplement if anyone has any questions. We've given you a little bit of data; we decided not to overwhelm you with data, but we will supplement anything you would like.

Dr. Sanders: [036:01:57] Thank you very much! We have time for questions from Commissioners. Commissioner Martin?

Martin: [036:02:08] I have one question. First of all, thank you for the presentation. I understand that overall there has been a 25% reduction in child deaths in the state, and a 30% reduction in intentional fatalities. I understand you don't have a one-line answer as to why that occurred, but I do want to know whether or not there has been some direct connection with the poster campaign that is around the city.

Specia: [036:02:30] Actually that is just starting. But we do have a very sophisticated safe sleep campaign, we have a drowning campaign, we have a number of public service messages going out at all times, and we are really committed to a public health approach of trying to prevent these fatalities. I agree with what was said by Dr. Berger, we made a dramatic change in children wearing helmets. Children just don't get killed that often anymore, and that was a change I've seen in my lifetime. I think we can make changes in certain things although I was really interested in the discussion of the Vietnamese families not having safe sleep deaths but other families do. We have a lot of Vietnamese families here, so the two researchers that testified first were brilliant, and I'm really going to be interested in reading their stuff, and my researchers want to talk to them, I know that for sure! [laughing]

Covington: [036:03:26] I was intrigued when you were talking about your workers doing things like safety checks in the home, looking for family violence, unsafe pools, and firearms strikes. That is sort of a new trend, I think, for child welfare workers. Can you talk a little bit more about it and when they do those kinds of checks?

Specia: [036:03:40] Well, last year we had a large decrease in the number of child deaths overall, but we had a significant uptick in the number of child deaths of children in conservatorship or foster care. So we did a review of all of our policies and we increased safety checks, we started looking at our data, and frankly I was shocked by the drowning data, the firearms data, and the safe sleep data. And so these are things we have to look at. And so we've trained our workers, we're focusing on safety, but we're focusing on identifying those risk factors in the homes when we go in.

Family violence is a terrible problem but also one that people don't share very easily. And so we are training our workers more on how to deal with family violence, how to recognize family violence, and then take appropriate steps and coordinate with the family violence providers.

No child should ever die of abuse or neglect. But if they are in the conservatorship of the state and a judge has given me that child to take care of we have to be very, very cautious. And so we have safety forums all over the state, we've met with all of our providers and all of our advocates, and we came with some standards. We've changed our licensing rules to require more reference checks, more safety checks, more unannounced visits, and we've come to the wisdom of the entire group to address it in a different way. We're in partnership with the providers to make sure we have safe homes for our children to play. I have 28,000 children in foster care on any given day, 10,000 are in kinship care. So there was kind of an attitude of like leaving kinship alone because they were stepping up. We appreciate them stepping up but we have to be aware of risk factors like pools, and guns, and people in the home that may have a

criminal record, those kind of things. We've got to be more careful on that kind of stuff.

Rodriguez: [037:00:45] Well I want to say I really appreciate those efforts. I think if we go in and remove a child from their home, the court intervention that we're providing them is safe, healthy, stable, and high-quality parenting in another setting. And so I think you're on sort of the leading edge with really focusing in to make sure that we're giving that intervention to children that we're removing, so I appreciate that.

But I was curious about the preventative services that you mentioned doing with families who have had a child removed previously for abuse and neglect, and I'm especially curious about the preventative services that you've developed for teens who are in foster care themselves who need a lot of support, and wondering if you could speak just a little bit more about what the preventative services are.

Specia: [037:01:35] We are contracting with a number of the people that do nurse-family partnerships. That is kind of the approach we are going to take. We're not going to a traditional investigation, it's a preventive approach. Some statutes, such as Michigan, allows that, but ours doesn't. So what we are doing is identifying it by computer search and then going out and offering services to those families. Being a foster child with a young child, I think, is a risk factor, and we decided that we were going to get services out and make sure they get help. It is really a variation of alternative response. We are going to go out and say, "How can we help you? You are in a tough situation, you've got a baby, what can we do to help? Make sure you've got a crib. Make sure you've got food." The resources are in communities if we can identify the family in need and match them up. So we are working on doing that.

Rodriguez: [037:02:30] So that I understand fully, are these services that are already being provided or are these services that you have just started to provide?

Specia: [037:02:39] We just started providing these services. This is a new service, it's a new match, we are just really in the first 6 months of doing it. It is something that we are piloting right now, and we are identifying those families and then providing services to them.

Dr. Sanders: Commissioner Petit then Commissioner Rubin.

Petit: [037:03:01] One comment is that I'm sure the Commission would love very much to see the specifics of the interventions in the last year that have knocked these numbers down as profoundly as they have. It is terrific. So I think we would benefit from seeing it. But let's go to the other extreme. From the early intervention and prevention let's just go into a situation where we have criminal behavior in a household, somebody that may not be related to the child, someone who has a record of breaking bones, and serving time, and just a very rough character in a household. What kind of relationship does the department have with prosecutors and with law enforcement, and is any of that in writing in terms of memorandums of understanding or joint training? What is the nature of the relationship with law enforcement?

Specia: [037:03:41] Well, I have 254 counties and the relationship is a little bit different in every county. The relationship in this community is a very close community; lots of joint training. I don't know if they have an MOU in this community or not. We have MOUs with the military bases. We have a large number of military bases. We generally have a good relationship with law enforcement. We have an excellent relationship with Department of Public Safety in our state, and we have a relationship with them that if we have issues with law enforcement they will help us and intervene. We have special investigators on my staff that are former law enforcement. They were placed on our staff probably six or seven years ago by the legislature to help facilitate that relationship, to help do more of the law enforcement type of investigation but also work with collaborating. Here in Bexar County, our two special investigators are based at the police department and work the CPS cases very closely with law enforcement. We have advocacy centers all over the state, and Joy Rauls is here, who is the statewide director. Many of those places are housed jointly, CPS and the law enforcement agency involved in doing the investigation.

Dr. Rubin: [038:00:02] I was encouraged to hear about the home visiting strategies and other strategies as preventative services. I think on the flip side my concern is that sometimes we hold up these programs as panaceas even by themselves, and they tend to be only as good as the kind of network of community services that are available to them. And what comes to mind, based on some of our own work, is the quality of subsidized child care, and particularly because we know that when moms go back to work who is there to take care of the baby? And it's often not the home visiting program, so can you speak a little bit to some of the other contextual services that wrap around families beyond child welfare, like child care and the availability of services to high risk families?

Specia: [038:00:50] We do have child care, we do have protective day care. So within the context of child welfare we provide day care for our foster parents and for our kinship families, and in our family-based safety services we have high-risk daycare being provided, protective daycare. I mean daycare is expensive and it is not free in Texas. And so, like I said before about the illegal care, there is incentive for some people to use a paramour or somebody who is not appropriate, not of age, and so those are challenges for this state. We could use more daycare services and I'm quite sure we could use more subsidized daycare services. There is somebody back there that can answer the question a lot better than I can, and I'll supplement my answer on that one.

Dr. Sanders: [038:01:45] I would like to ask one last question. Thank you very much, Judge Specia. You mentioned earlier that fewer than 50% of the children who had died were known to the system. When you talked about a lot of the prevention efforts of your agency can you say a little more, and this builds on what David Rubin was saying, a little more about are there prevention efforts beyond the work that your agency is doing?

Specia: [038:02:10] Oh yeah! This community is a good example of it. There are many, many prevention efforts in this community completely separate from the child protective services agency. There are child care providers that provide care outside the child protective services system completely! All over the state we have efforts of prevention being developed. We have our money on prevention that we just got from

the legislature and we are focusing on using that in communities; not just telling them what they can buy but going into the community and doing a needs assessment and working with the community to decide what they want in their community to address their problems. And we are looking at a partnership. We are not going to pay 100%, we're going to partner with the nonprofits, the foundations in the communities to spread the level of resources through the community. I'll send you some more data on that. My PI director is here but she has been really working on building prevention efforts all over the state.

Dr. Sanders: [038:03:13] Thank you very much, thank you for taking the time. We are very fortunate to have Congressman Lloyd Doggett, who has just joined us. He represents San Antonio's Southside and Eastside neighborhoods, which we are in. He serves as ranking member on the Ways and Means Human Resources Subcommittee that handles child welfare, child support, foster care, and adoption issues, and his Protect Our Kids Act established this Commission, which was signed into law by President Obama in early 2013. Last year he was named Public Official of the Year by NASW, and received the Bud Cramer Award.

Congressman Doggett: [038:03:52] That is a good recommendation with this collection, isn't it? [laughing] Even though Bud is watching from afar. Thank you so much, Mr. Chairman. I look forward to this visit and later, after the Commission concludes this afternoon, informally at our reception. I appreciate the chance to visit with you again. I enjoyed talking with you in Washington in February. We've made some progress in one area since then. Certainly, Judge, it was good to hear from you first hand and to know what you're doing to try to reform this whole effort. I think that just listening to the judge now talk about the challenges here in Texas, so much of what you've been doing, from the details of the data earlier this afternoon to the recommendations that you make will be important to efforts at the state level and our efforts in Washington to say, "We know we have a consensus of members who care about this issue, but if we're going to get some action what should our priorities be in a tight budget situation here and in Washington? What seems to work and what is the actual data?"

I got a little frustrated when we had our first subcommittee a couple of years ago and heard various experts talk about the data and how many children die per day. Whatever the precise numbers are, and it is good to have precision and uniformity in that data, I don't in any way belittle the importance of it, but it's clear that too many are dying and that we need to focus on what we're going to do about it. I continue to be optimistic that there is a strong bipartisan consensus in Congress to our trying to resolve this question, but the budget pressures are very real also.

I'm very appreciative of the fact that you accepted the invitation to come here to San Antonio for this first field hearing. People think of San Antonio as the Alamo City and this week we think of it as the Spurs victory city [laughing]. But it is also known throughout Texas as Military City. And when I hear some of my colleagues talk about the fact, we don't want to just throw money at the problem. I think about how they might respond if we were talking about national security instead of the security of individual cities. Yes, when it comes to the Defense Department we need the audits that we never can seem to get out there, but we need good fiscal responsibility and efficiency there, but we don't think we can assure our national security by just

throwing words at the problem. And here we lack the resources, as the judge just mentioned, at the state level and nationally, and we can't just throw words at this problem. We've got to be able not to throw money but to see that we make efficient use of greater resources to deal with the challenges we face. And we just heard outlined a number of those.

I got in just as Senator Uresti was finishing. He has really been our leader on this. He is responsible for much of the attention that I personally have focused on this because of the example of leadership on child abuse that he has provided here in the state.

I know you're going to hear also from my personal state representative, State Representative Dawnna Dukes, who has formed a similar commission effort over in the House of Representatives in Texas.

Securing the funding that we need to reduce caseloads for professionals in the child welfare system, I think, has to be a priority. We talk not only about caseworkers, but in February about court personnel and other aspects of this system. I believe that the most recent report that I saw said that about 38% of the child welfare caseworkers here in Texas quit within the first year. And they certainly have caseloads that are overwhelming and far exceed what many have recommended as the standard for caseloads. When you have that many people, who are viewing this as an entry-level job, overwhelmed and getting out of it just as soon as they can, you don't have the consistency and the professional career ladder necessary to ensure we have the right people working on this problem. And we know from numbers, whatever the specifics turn out to be, that this is an urgent matter. We hear about one particular instance that has gotten considerable attention here in San Antonio, another in Austin that people react after the fact. And what we need is not to just throw words after the fact but to try to respond with effective prevention alternatives. And I think that even though a thorough consideration that this Commission is making is underway, that we know many of these changes will occur on both state and local levels. We talked about home visiting during the February meeting. You have referenced it already here this afternoon. Fortunately, that is one small bit of progress that we had in Congress in getting the program extended for another year, although it is very unclear what happens next and how we proceed after this initial year of funding. There is not a dedicated funding service available for that.

One policy option that I think is worth exploring is allowing the federal title IV-E matching funds to be used for preventive services rather than limiting the funding to after-the-fact foster care services. In 2011, I co-authored legislation that authorized demonstration projects to allow all states to use their existing IV-E money on a broader range of services, and I think it would be helpful for the Commission to explore that as an alternative in the future. Certainly more funding is needed to provide treatment for parental mental health problems, including substance abuse and postpartum depression. I just visited here about two weeks ago with a group of attorneys, attorneys who are representing children, who said, "If we could deal with some of these substance abuse problems we would eliminate a very significant portion of our abuse and neglect challenges." A significant amount of mental health funding has been available through SAMHSA, the Substance Abuse and Mental Health Services Administration, but authorization for most of the SAMHSA grant programs expired over a decade ago and the block grants have certainly not grown in the past 15 years to

keep up with inflation. The legislation that we had in 2011 allowed the states to fund some substance abuse for caregivers using funds that were traditionally allocated for foster care, and that is worth further consideration.

Ensuring that our expectant parents have the basic training that they need to care for their children, through the nurse/family partnership, is one aspect that I think even having them see the most basic videos on safe sleeping, on how to deal with crying and the like would go a long way in saving lives. In the parental training of this type, exposure to these types of issues needs to begin with our high school health courses. Some high schools are doing this, but we really need to send a signal out that every health course ought to include a little bit about parenting.

Collaborative responses to neglect and abuse, such as those coordinated by child advocacy centers, or CACs, in more cases could help pull children out of harm's way before more damage is done. Encouraging child welfare law enforcement and criminal justice workers to cooperate, I think, can help ensure that a young child does not remain in the hands of abusers while an abuse case is waiting on a crowded court calendar. You're going to hear shortly from Judge Peter Sakai, who has been one of our other key leaders here for at least a decade, working with CASA and other groups, and I know he can provide much more insight into what happens at the court end of this.

So I think that there are a number of specific objectives. I don't think they all have to come out at the end of the Commission's work, but the interim recommendations can come out. Probably not too much more action than the approval of appropriation bills in accordance with the budget agreement from last December, but come November, if all of the work that has been rumored and promised for Congress to do between the election and the end of the year we'll be meeting 24 hours a day. I don't know how much of that will happen but we'll be through another election cycle and perhaps able to begin to focus on some of the recommendations you have after the election, and then when a new Congress comes into place in January.

In Texas, as you know, our legislature meets only every other year, and so it also, in the aftermath of several very well-publicized and tragic cases here, has a chance to look again at the resources that it allocates to many aspects of this problem. You are going to hear from our friend Madeline McClure, who came and testified to the subcommittee in our establishing this Commission but also, in this kind of budget situation, was able to squeeze some additional prevention funds and some legislative changes out of the Texas legislature. So I really am here mainly to welcome you, to suggest these few specific ideas that might be worthy of your further consideration, but to say I'm pleased that you've come to see the problems we have here in the San Antonio area and in Texas, but also some of the solutions we have to offer. I think that so much of the work of the Commission, other than arming elected officials and administrators with the facts that we need to make the case for more reform and more resources is to share best practices, that as you go around the country and see things that are working, that also is a part of your interim reports and recommendations that we draw those to the attention of everyone who cares about this.

In closing, I want to thank Randee for her coordination with our staff and to thank UTSA for working with us to provide this facility. I look forward to sharing a little time with you individually this evening and welcome any questions that you might have.

Dr. Sanders: Thank you very much. Commissioner Horn.

Dr. Horn: [041:00:20] First of all, thank you again for your leadership on this issue in Congress, Congressman. We heard from Commissioner Specia that second on his list was greater flexibility to use IV-E funds for prevention work. As you know, there are two difficulties with that, even though under your leadership they reinstated waivers to allow states to have the ability of more flexibly spending that money for prevention and not just for foster care. The number of waivers that were allowed was limited, and there is this little thing called “cost neutrality” which says that you can’t spend any more money than you would have gotten anyway, and if you spend less money this way the federal government takes back what you didn’t spend.

So two questions: Not to put you on the spot but we’re all friends here. What is the likelihood that the cap on the waivers could be lifted? And secondly, what is the likelihood that there could be some movement on the cost neutrality, maybe not opening up completely but maybe saying you could get a 10% bump up if you do a flexible funding? [Inaudible] to actually think about prevention as a way of reducing not just fatalities but child abuse and neglect generally.

Doggett: [041:01:55] Well, I think I would say, first, that the chances of getting an affirmative answer on both of those questions are improved with a strong, unanimous recommendation from the Commission. I don’t want to just pass the buck, but come November, as you know, we’re going to be entering an entirely new budget period. Our budget agreement will have ended, we’re looking at how we deal with all aspects of government cost. That is an appropriate time, as we try to work through another way of dealing with sequestration and our overall budget challenges for the next two years, to raise those very issues. I would like to see something done along the lines of what you suggested, Commissioner, on both those issues. I think we begin laying the groundwork for acting on it now, but that we are looking at an action period of early next year or even, in the unlikely event we can get the beginnings of a budget agreement approved in the post-Thanksgiving period.

Dr. Sanders: [041:03:01] Thank you, Congressman Doggett. I had a question about you mentioned the interagency work, like the CACs you used as an example. And one of the issues that we’ll be addressing is confidentiality. And obviously, the sharing of information is critical. Can you say a little about if that is an area that we are focused on, the likely receptivity from Congress?

Doggett: [041:03:30] Well again, I think the Congress will be willing to listen if there is a strong, unanimous recommendation from you, and particularly if we hear from some of the other groups that have been concerned about that and they join in that recommendation. I think it is not only going to be, and that is why I’m suggesting the possibility of interim recommendations before you complete all of your work. We need a buy-in from some of the groups that have been most concerned about confidentiality in the past. I think the idea of sharing across lines similar to the CAC model is the way that we need to go.

Dr. David Sanders: Commissioner Petit.

Petit: [041:04:09] Yes, I think that Congressman Doggett, today and earlier and elsewhere, has emphasized this point repeatedly, and I think we need to pay heed to the fact that on an interim basis there should be something foot-forward on this. The confidentiality one, I think, is critical because one of the issues, at this point, is that the public does not really see how this work is done. And in many cases lawmakers themselves are not permitted to see information. So I think our coming up with something and working with some of the groups that you talked about, everybody believes in transparency and no one wants to unnecessarily make a case not confidential when it is appropriate. But on the other hand, the only way we are going to go forward on this is for the press to help educate the public and build the political will that you're talking about in that magic two or three weeks following Thanksgiving. So I'm hoping that the group will be able to formulate something that can respond to this invitation.

Dr. Rubin: [042:00:09] Thank you, Congressman Doggett. We tend to focus on child welfare funding, and IV-E, and we probably spend a little less time thinking about health care funding, particularly Medicaid. And with the Medicaid expansion going on in many states nationwide right now there is a real opportunity to talk about adverse childhood experiences and the treatment of young adults who are now getting coverage for the first time and who are parents of these young children that we care about. There is plenty of data telling that provision of services, particularly in mental health, for parents can actually have a dramatic impact on the well-being of the children.

So I guess it is more of a general question. Are there opportunities with the expansion of Medicaid with the provision of health insurance to a lot of Americans who have never had it to really start to address some of the fundamental issues that are underpinning some of the issues we're addressing?

Congressman Doggett: [042:01:06] Well there are, and it is an extremely important area. With the Supreme Court decision as it was and the option of the states whether to join in, it is very troubling, despite the leadership of Senator Uresti, Representative Dukes, and other members of the delegation here. Our county judge here in Bexar County was with us in Austin when we sought expansion of Medicaid here in Texas and even said that he would reduce local property taxes if that was done. That usually is enough in Texas to get something like this approved, to get this federal government to give us 100 cents on the dollar, but it was not, in this case. I hope that more and more states are seeing the benefits to their families of accepting those federal dollars to get this program underway, and I view it as very essential and it really is related to this basic issue of child deaths because of the needs those families have. I had, within walking distance of where we're gathered here, a major health fair earlier in the year and the number of people who came in responding to reports of being able to get access to health care who we had to turn away because they were too poor to qualify was really, really disappointing. And so I know that has been an area of considerable partisan controversy, but there ought to be bipartisan recognition of the benefits for child abuse, mental health, and other issues that we face.

And I also really applaud the question that you asked earlier about child care because of getting access to child care that is affordable, is safe, and can provide a learning environment. I see Dr. Kathy Fletcher here with Voices for Children, which has been so important here in San Antonio at advocating for that, but we really need more help in that area.

Thank you, Mr. Chairman, thank you so much for your being here and I look forward to a further visit on an individual basis. I really appreciate your commitment.

Dr. Sanders: [042:03:30] Call up Judge Peter Sakai from the Bexar County Children's Court.

Hon. Peter Sakai: [042:03:39] Thank you very much. Good afternoon. It has been a long afternoon I want to thank Representative Doggett for your leadership and being a sponsor for this particular Commission and the legislation that created it.

One of the things I do want to recognize are the key players, and those are the people in the room and those are the people that are going to come speak to you, and I think you're going to pretty much get all the key players that are making things happen here in Bexar County and in the state of Texas in regards to child welfare.

One of the things that would give you a perspective in listening to all this, and it does get long and those seats are hard, let me tell you. But at the same time, just like what I have to do for a family, especially my Bexar County Family Drug Court that Judge Specia created 10 years ago, when those families come in I have to look at them almost like a broken jigsaw puzzle. The pieces of the puzzle are all over the place and it really is key that we have a team approach to put together these pieces of the puzzle together. And that has been one of the key successes for our Bexar County Family Drug Court, with a 1% recidivism rate. And so we're very proud of that.

And basically, what I submit to you is that you're going to have to take all these snippets of information, details, programs, numbers, the doctors with the outcomes, and piece it all together in the best way possible, and then develop some coherent vision and give some direct guidance to Congress, because what it boils down to is an issue of funding.

I also want to recognize that I come with several hats. I serve on the National Council of Juvenile and Family Court Judges, where I was and still am on the board with Judge Martin, and I served as chair. I also serve on the Texas Supreme Court Commission for Children, Youth and Families, that is Chaired by Justice Eva Guzman, and I believe we have some staff people, Tina [inaudible] and Heidi [inaudible], who are here in the room. I'm also on the board of the Texas Senate Judiciary Committee, which is in charge of judicial education for all the state judges here in the state of Texas. I'm also quite proud that I'm also part of the Blue Ribbon Task Force with Senator Uresti, and we go back about 10 years with that, and he has been a leader here in the state of Texas, especially in the legislature. And finally, I come here as a district court judge, having succeeded my friend and mentor, John Specia, and I've been doing this work for over 20 years. I started over in juvenile court as a judicial officer with Judge Tom Rickhoff, and then ended up working doing a child abuse and neglect for Judge Specia, and I am now a sitting district court judge here in the state of Texas.

So I had a conversation with Randy and said, “You know, I don’t know if I can give you the answers,” and that is the reason why I used that jigsaw puzzle; I’m not coming here with answers. But what I wanted to do is perhaps pull back a bit and give you a perspective of what has worked here in Bexar County, and I may not really give you answers in regards to child fatalities, but basically, the strategies and tactics we have used and what I have learned.

One is judicial leadership. And judicial leadership is to use and employ the judiciary as a key and a leader of the community. That is something I learned back with Judge Rickoff, when he was a juvenile court judge, and Judge Specia. And basically, those were a lot of training and strategies learned from the National Council of Juvenile and Family Court Judges. I think it is key that you look at your judges because what I have come to realize in my many years is the public will look to the judge as the impartial arbitrator, not somebody with a set agenda say, “Okay, I’m here to sell a program, I’m here to fix things.” What we do every day is statutorily do what is in the best interest of the children, which goes back to creating that child-centric vision and strategy that I think any system needs.

So what I would suggest to this Commission is that you do not ignore, do not marginalize, or put the judge aside and say, “You are the judiciary and you just hear these cases, so come and talk to us and tell us what is happening,” but rather you employ them because they are judicial leaders and they can put people in the room to fix things, especially on a local basis.

One of the things that we’ve done here in Bexar County is we really focus on data. I love the conversations of Dr. Berger and Dr. Gulino. And we can go all over the place with stats, so again, it really depends on the locality and the key players, and you will hear the key players soon as they come and explain what we’re doing here in Bexar County. But one thing I’ve come realize, it has to be outcome-based! It has to produce! It has to create results! Families must be put back together! Families must be rehabilitated! We need to recognize the complexity, because we can be all over the place with the complexities and the issues that deal with culture, that deal with disproportionality, that deal with drug and alcohol addiction, family violence, and the access to mental health.

What we’ve learned here in Bexar County is to do things in a multidisciplinary way, especially with our metrics of our family drug court. I have 20 stakeholders at the table, and you are going to hear most of them here in these Commission meeting, from James Castro, St. Peter, St. Joseph, at the assessment center, Annette Rodriguez, Children’s Shelter who runs the fatherhood program called Compadre - Compadre that we utilize. We have our treatment providers that provide for drug and alcohol addiction. We have reached out and dealt with the homelessness issue, and I don’t know if anybody is going to talk about that, but we have a state-of-the-art national program called Haven for Hope that this community put in place. It is a multimillion dollar program that is really comprehensive and uses the same strategies as what we have learned to do in the court system.

What do we need? It has already been said. It is funding! But let me be very specific in light of the issues that I have brought to you as to what has worked; what we need to

do is continue to train and educate the judges to be the leaders in the community. We need to support the National Council of Juvenile and Family Court Judges who do that throughout the country. Tell judges, “Get off the bench, go out into your community, talk to people, make consensus, have all these issues of confidentiality to hopefully not be barriers but opportunities to come together and communicate.” What we especially do is MOUs! We just put it all in writing, we keep it all out, and basically we have everybody be able to provide direct impact and direct feedback on what is needed in their community.

We need to create and develop best practices. One of the things that Dr. Teasley touched on, and one of the things that we do every day is to make sure that we have trauma-informed care! And one of the things we learned from National Council is judges need training on that. They need to be taught that these families come in broken and they need to be dealt with in an appropriate way. We also know that disproportionality is a big issue, as it deals with appearances to our community or to our society. And it has been brought in the room that cultures have a different way of dealing with things, so instead of compartmentalizing it and saying, “Well let’s do certain things a certain way,” let’s just respect and encourage diversity.

Finally, let’s break down compartmentalization rules. What we have done here, and I don’t know if other people will touch on it, is we got an 1150 waiver on mental health, which is just going into effect. And we are hoping it will increase access to mental health on a local level. We have developed programs with our domestic and family violence advocates, and you are going to hear from Marta Peláez how we are one of the few jurisdictions that really works together. Some places are still trying to define what is appropriate for protection of the children, what is protection of that spouse, or that life partner. But what we are dealing with here is effective programs that bring these families, these parents into the room to what we called Batterer’s Intervention programs. Not just anger management where we tell people “Chill out,” but we put people through a program to basically help them understand that the culture of violence destroys families and it ultimately ends up with child fatalities.

We also have learned that drug and alcohol addiction is a big issue and what we hope to do and have done as judges in this community, and especially in our drug courts, is a big program here in this community where we have been able to draw down and basically go back to the funders, such as SAMHSA and the state through the governor’s office and convince them that we have outcome-result based programs that work and they need to be funded. So we don’t come in here selling anything, but we come in here showing that we do have results and we do make a difference.

So let me just close with this, I don’t know if I’ve answered questions in regards to fatalities, but I hopefully have given you a path, a process, a way to come up with the recommendations you need to do. It is going to be awfully difficult. What works here may not work! We have seen that here in Texas, what works in San Antonio doesn’t work in Houston and vice versa. But what we have learned is we have unique situations, we have tremendous difficulties, we have the highest teenage pregnancy rates, but we’ve got the Healthy Family Program with Dr. Janet Realini, who has brought that statistic down every year for the past five years. We have a mayor who is soon to be up in Washington, DC [inaudible], and he created a Pre-K program. So we

are seeing programs that we think, on the long term, are going to create a healthy environment for healthy, nurturing families.

Thank you all very much.

Dr. Sanders: [044:04:43] Next speaker is Laurie Charles from the Texas Child Fatality Review Team, and also at Santa Rosa Children's Hospital.

Laurie Charles [45:00:01] Thank you very much for having me here, Commission. My name is Laurie Charles, I run the Forensic Nursing Program at Children's Hospital of San Antonio, right across the street. I want to talk a little bit about my role as a forensic nurse and my role as the chair of the Bexar County Child Fatality Review Team.

So our Bexar County statistics: 24,000 completed DFPS cases, 13 confirmed victims in 2012 per 100,000, and 19 child abuse-related deaths. Our forensic nursing program has two programs in town that take care of sexual assault. We have an adult program in town and we have a pediatric program, and mine is the pediatric program. We take care of sexual assaults, we take care of child abuse and neglect in the emergency department.

So you can see our statistics haven't really changed too much. The "SA" is sexual assault, and the "PA" is physical abuse. That doesn't mean that we have said, "Yes, that absolutely means that they were physically or sexually assaulted," those are just children that we have seen. The "consultations" are somebody is concerned in some form or fashion that maybe a child was sexually assaulted and so we see those children. Normal sexual assault programs don't see those children. You normally have to have law enforcement involvement and law enforcement approval for the exam. We see those kids regardless, and more often than not those are children who are children to moms who were sexually assaulted who didn't get the care they needed when they were children and so they are bringing their children in because they are hyper-vigilant moms and just want to make sure their kids are okay. So we get to see a perfectly healthy kid, we get to tell the mom, "Your child looks perfect."

So things that I think are working here in Texas are we have great interrelation. The Texas Family Code allows us to examine a child without parental consent if we are concerned for abuse. So if a parent says, "I am declining to let you check my child," we smile very kindly to them and we check their child anyway, because more often than not the abuser is a parent. And so I think that is an absolutely wonderful thing in the state of Texas!

Also, the Code of Criminal Procedure says that there will be joint investigations between CPS and law enforcement. So rather than CPS starting an investigation and law enforcement finding out about it days or weeks later and then trying to catch up, they are working together. What our forensic nursing program does is we make two phone calls; Texas law says you must report. It doesn't say who you must report to, it says you must report to a reporting agency. We report to CPS and to law enforcement so they can both start at the same time. I think that is an incredibly important strength in the state of Texas.

HIPAA, the health information protection, reporting to law enforcement and CPS completely supersedes HIPAA. When HIPAA first came out people were very worried and they wouldn't release information to law enforcement and CPS. That is just not an issue in our community. We release immediately to law enforcement and CPS so they can do their investigation to make sure these kids are safe.

Our Bexar County strengths. This is coming from somebody working in the Children's Hospital of San Antonio so take it with a little bit of grain of salt. I think our program is spectacular! [laughing] We have a Center for Excellence in Bexar County run by Dr. Jim Lukefahr, and you will hear from him tomorrow, and the Chair of the University of Texas Child Abuse Department is Dr. Nancy Kellogg. She is our Medical Director and she is nationally recognized as an absolute expert in the area of child abuse.

And so we have their phone numbers and we can call them anytime day or night if we need any assistance. CPS and law enforcement, I also have their phone numbers and can call them anytime day or night if they have any concerns.

Our forensic nursing team at Children's Hospital of San Antonio has more than 60 years of forensic nursing experience. Not nursing experience, we have hundreds of years of nursing experience, but forensic nursing experience. We take care of child abuse, neglect, concerns for child abuse and neglect, assaults, elder abuse, different kinds of things. We handle all of those sort of things. I think the importance of absolute expertise in this field is vital!

The Center for Miracles is our child abuse treatment center. It is housed on the campus of Children's Hospital of San Antonio. There are child abuse pediatricians there. I can't say enough about the importance of child abuse pediatricians. When child protective services is trying to make a determination, "Do I keep a child in the home or not?" and they are looking at medicals, they don't understand what they are looking at. And that is nothing against child protective services. I don't understand how to do their job. But they need strong medical personnel that are willing to say, "This is abuse," "It isn't," or "I don't know," and maybe you guys could help us get information. And that is what child abuse pediatricians do. I think that our child abuse pediatricians are spectacular...did I say that already?

They have child abuse pediatricians, they have a fellowship program, and the National American Academy of Pediatrics Fellowship Program was actually written by our Medical Director, Dr. Kellogg, and was accepted by the American Academy of Pediatrics to be the way to set up a fellowship program. They have social workers and a nurse practitioner there.

More about Bexar County strengths, everybody's working relationship with each other and how we interact, it is the importance in the health and welfare of the children versus "I live in my silo and I can't give you any information because I live in my silo." We have frequent meetings where we are all at the table to discuss cases, and it is not a, "What did you do?" it is "How can we make this better?"

DFPS houses child protective services liaisons in the four major health care systems in Bexar County, and I think it is absolutely brilliant because child protective services is right in the hospital, and I can go to her office and say, "I called the hotline and I'm

not sure they understood what I just said. Can you look at this?” When we are on the fence with a case, “Should we call it?” “Shouldn’t we call it in?” we sit down with the child protective services liaison, he or she looks up the patient and goes, “You need to call that in!” and smiles very nicely at us and does not share more information, but tells us the importance of calling in that case so they can do an investigation because they know something more. They have senior investigators in San Antonio Police Department substations so when they are doing investigations that senior investigator goes out with the SAPD officers to the scene. I think that helps with their investigations of these cases also. We have serious injury staffings where child protective services sits down with a child abuse pediatrician so they can help understand what is going on with that case, and we have the multidisciplinary meetings like I talked about.

The Child Fatality Review Team members are all there, and you had some questions about confidentiality. Every time we have a child fatality meeting every member signs a confidentiality agreement when they come into the meeting so they know that we are discussing confidential information.

We bring back cases if we need to bring back cases. We will report cases to outlying communities because we have two trauma centers. We have children die here that aren’t from Bexar County so we will report those back to other state child fatality teams so that they can review them in their own community.

Dr. Sanders: [046:04:06] Thank you very much. Our next speaker is Jose Luis Morales. He is an Investigative Supervisor with the Texas Department of Family and Protective Services.

Jose Luis Morales: [046:04:24] So as he mentioned, I am a supervisor for child protective services here in Bexar County, specifically a Night Unit Investigations Supervisor. So what that entails is essentially, after a certain time, when the people who have lives, the 8:00 to 5:00 people go home, we take over. So from 4:00 p.m. to about 8:00 a.m. all child fatality or any CPS investigations will come across my desk. So if I get into details about child fatality protocol here in Bexar County or with the state we would be here all day, so I will briefly just touch on how swift it is.

I have personally been doing this for a while. I have a lot of confidence in our system. We typically assign two investigators right out of the door, and that includes a special investigator who has law enforcement experience and one of our own investigators. We do work closely with law enforcement and with Santa Rosa Hospital trauma specialists regularly. We touch base with the Medical Examiner, and we even have our own committees in house, especially here in Bexar County, where all of our superiors, prior investigators who work for the family, any social workers that worked for the family, and we sit down so at the outset of this child death investigation we sit down and say, “How can we proceed from here? What does the family need? What has been done in the past to address any issues that the family may have?” And it can be pretty extensive in some cases. One point I want to touch on before I end here was the emotionality of a child fatality investigation, which is typically not looked upon or is sometimes passed over. When a caseworker touches base with a family for a child fatality investigation I can tell you it is enough to just drop you to your knees. It is stuff that will stick with you your whole life. A lot of times our caseworkers aren’t

prepared for something like that. We do our best to prep them as to what they are walking into. I can assure that trying to talk a family into doing a safety plan, which is essentially if there is risk involved with the case or safety factors we have to address with the family, they have to be supervised with their children 24 hours a day. So implementing a plan like that when your child's body is a few feet away...I mean to say the least the parents aren't too receptive to it. So it is a challenge for investigators.

Also, if you have a high caseload and a child dies on your workload the guilt that investigator feels, just based on that, is tremendous and, again, I know. I have experienced it personally and it will stick with you the rest of your life. Some of our case workers, Judge Specia had mentioned Family-Based Safety Services, a program we have here in this state, and these social workers will be assigned, based on the investigator's work, to work with a family for anywhere from 3 to 6 months, sometimes longer. We have legal workers when a child is brought into care that will work with the families for sometimes years and with the children sometimes years. So they build real bonds with their children and their families, anywhere from Christmas gifts every year, birthday gifts, buying the groceries, buying them beds, and so when a child passes it really is a huge impact on the caseworker. We do have some services to help with that, such as the Employee Assistance Program, or EAP of the state offers counseling services free of charge to the caseworker and time to kind of step back away from their caseload and reflect on what has been going on and any areas where we can improve in our investigations we discuss. One of the other responses to a child fatality is called the Quick Response Team here in Bexar County. What we do is sit down with child safety experts and risk management experts that we have assigned and go through any prior investigations and say, "Okay, we have seen this family before. Where did we go wrong?" and I say that because like I said our nature is we protect children, that's our job, so again, a sense of guilt. Where can we improve? Where can we spot risk factors and offer them services where we didn't before to try and avoid where we are at.

So as far as relevance to our committee, they asked me to come up with what, from my point of view, preventive measures I think we can expand on, and there are two things. Again, because I'm in the night unit we see absolutely everything. We have a large amount of child fatalities that we've worked. The two that I see the most common, and in fact I have three sitting on my desk just over the last three months, is drownings and co-sleeping. We have discussed a lot about safe sleeping, and even Judge Specia mentioned a poster campaign, which I brought one of the posters they were speaking of, and I think a PR campaign for the funding of the PR campaign to put the word out there about safe sleeping is, in my opinion, one of the most important. It is just so tragic and so preventable, in my opinion. But we do see a lot, and that is across every socioeconomic spectrum. I have seen them in every different type of family. It really does need to be common knowledge about safe sleeping conditions. I heard a point from our Congressman about implementing a high school program to teach such things, and I think that is genius! I think as soon as you can get it in, it really does need to be common knowledge.

Dr. Sanders: [047:04:47] Mr. Morales, thank you very much! That is very informative.

Covington: [047:04:56] Thank you, Mr. Morales, and I appreciate you kind of bringing this to the human side in terms of what this means for workers. But I have a question, because I think one of the things that is really important in doing these investigations is the concept of joint investigations, and you mentioned that you do them together. But you said that you put two investigators out the door. What triggers you going out the door, is it any death of any child or is it just a death that someone suspects might be abuse or neglect?

Morales: [048:00:25] It is 99% if the child has passed away in Bexar County then typically we get involved. I mean if it is an obvious long-term medical situation that wasn't preventable, and it was a parent, and we've talked to medical professionals then we'll hold off.

Covington: [048:00:39] Who calls you? Because I think it is admirable that you become involved as part of the investigative team. Where do you get the call from most typically?

Morales: [048:00:48] Anywhere and everywhere. Sometimes we get family members who have called it in because it slipped through the cracks and they say, "Hey, FYI, this child committed suicide," or hospitals, law enforcement, anyone and everyone. We get them from all over.

Dr. Sanders: Commissioner Rodriguez.

Rodriguez: [048:01:05] Your job sounds incredibly challenging and I'm just curious, you mentioned one area that investigators aren't getting a lot of support or training on how to deal with it. And I'm just curious, the investigators that work in your unit, do they receive special training or is there a sort of requirement that you work for the department for a number of years before you take on this task that sort of the entire child protective services revolves around? Can you talk a little bit about that?

Morales: [048:01:37] That is interesting you should bring it up because that was actually my final point before I ran out of time, is that I think if another area was to be expanded upon it is training and those types of areas. I think no matter what services you have, or what programs you implement, your front line and how your caseworkers approach the families will essentially make or break. I mean the family being able to relate to their caseworker will pretty much decide whether they are going to retain the information you are giving them or not, whether you are going to be receptive to the services or not.

Rodriguez: [048:02:05] Then would you describe your front line workers as sort of the most experienced, highly-trained workers in the department?

Morales: [048:02:10] I take credit in my people. I mean I try to develop them as much as possible. I give them a code name, "jedis." [laughing] So I mean I try to develop them as much as possible, but that is something I took upon myself to try and bring them to a certain standard, to get them to know, "Look, you are in the Night Unit, you are going to get bad cases regularly, you need to be prepared for it."

Rodriguez: [048:02:30] So that has been your mission as their supervisor, but not necessarily departmental policy that this is the highest level of training and experience, so we are going to put people in that position.

Morales: [048:02:40] I would definitely like to see more of it, yes, as a standard.

Dr. Rubin: [048:02:46] Yes, I had more of a comment. I think that in this situation where we are dealing with child abuse and neglect fatalities, in the media the story that is often told is finger pointing, and how people haven't done their jobs. And just listening to you, and based on my experience as a general pediatrician working with folks and the Department of Human Services in Philadelphia and elsewhere, I just want to thank you for your service because I think this is a story of professionalism and empathy that people rarely tell the media about, and your respect for your job.

Martin: [048:03:19] I have one comment and I have one question. My comment is that I think it is admirable that you look at it as, "What did I do wrong," or "What did the department do wrong?" I would encourage you, however, to look at it from a standpoint of "What did our system do to fail this child and this family?" because I assure you judges feel just as bad. And I think it is important for all of us to take some responsibility so that we can all look at what we can do better the next time around. So although I am very encouraged that you have such empathy I would certainly suggest that and encourage you to look at it as a system-wide failing as opposed to an individual worker failing.

My question to you, and certainly thank you for your testimony, is I may have misunderstood, is your responsibility only to respond to fatalities and near fatalities or is it any hotline call, for instance, that comes in during that period?

Morales: [048:04:22] So we have limited personnel, as you can imagine, so we are a priority unit, and by "priority" I mean the higher the gravity of the allegation. So we prioritize amongst those, the worst cases, and we attack those. So there is child fatalities, there is sex abuse cases, near fatalities, infant skull fractures, fractures, shaken baby, anything and everything that needs immediate response we go to.

Martin: [048:04:50] And it is triaged by the hotline?

Morales: [048:04:53] Most times, yes. Sometimes law enforcement. There won't be time for it to go through the whole statewide intake process and get the report to Bexar County, so law enforcement can call us directly or call the hotline and say, "Hey, you need to have the supervisor for this call me directly," and we'll go out immediately before the report gets to us.

Dr. Sanders: [049:00:15] Thank you Mr. Morales. We have next Madeline McClure, the Executive Director of TexProtects.

Madeline McClure: [049:00:26] Good afternoon. My name is Madeline McClure and I am a founding Executive Director of TexProtects, which is the Texas Association for the Protection of Children, and previously I was a clinical therapist working with severely abused and neglected children at one of the advocacy centers. I am also the lieutenant governor's appointee to the Protect Our Kids Commission in Texas, and I

was supposed to be on your Commission but I guess I applied too late. Anyway, congratulations to all of you and also to Commissioner Doggett for this wonderful legislation.

I am just going to touch briefly on how child abuse and neglect fatalities are counted in Texas, some obstacles, and then some solutions as to what is working.

In this particular slide you will see the strong orange line, the trend line is our child population growth from '97 to 2013 in Texas. And as Commissioner Specia mentioned, that has been growing by about a million. This chart looks like it is about flat. But as you can see, our child fatalities over that same period and that trend line right below will show you they are increasing. In fact, if you look at our child abuse and neglect fatalities they have grown, on average, by three times the average population growth annually. I wish we could say that drop off from the peak of 280 to 227 was attributable to prevention programs, but unfortunately I did learn from the field that there was an informal policy through the safety specialists from state office asking all of the front line workers to use a more stringent definition of child abuse fatalities.

So Texas does not count all the cases in which child abuse was substantiated and a fatality occurred. So you can substantiate and say, "This is confirmed abuse," but there is an "unable to determine" because that fatality didn't occur directly because of that day's neglect. Again, I think we've all touched on this, and it has a way of artificially decreasing. Whether it is a good policy or not the problem is we don't have an apples-to-apples comparison to find out whether it is a decrease in prevention programs or an increase that are going to make a measureable impact. So just our recommendation on that is that Texas and all states should count any substantiated, verified abuse in which a fatality occurred, and that would be more indicative of the number of child abuse and neglect fatalities, and then we really can pull that information from our existing system.

And then secondly, one of the issues we've been talking about are near fatalities. In Texas, if a near fatality results in subsequent death and that case has already been closed it is not re-ruled in the impact system as a death. Only if that case was still open, let's say in foster care. So that has got to be another change so that, again, we are accurately counting real fatalities. Our disposition is "a reason to believe," it's moderate, serious, severe, near fatal, and fatal.

So I'm going to just touch lightly on some of these obstacles in reducing fatalities. Our impact system, which is where we enter all the data on child abuse cases, leaves a lot to be desired, and I'm sure this is not just unique to Texas.

The data, as many of you know in your systems, is not always quantified. There is a lot of information in the caseworker's narrative. I used to work right next to the caseworkers so I really feel for them. But it makes it exceptionally difficult to test multiple hypotheses, possible predictors of child abuse fatalities, as you discussed earlier. And the importance of the effective data collection and usage is exemplified by this massive research study in California. In 4.3 million children who had prior allegations of abuse, even if the CPS report wasn't substantiated or verified, proved to be the strongest independent risk factor for any injury-related fatality in children under the age of five. And I believe Dr. Berger mentioned that earlier, but I just want

to emphasize how important initial reports are, even if they are ruled out, even if they are administratively closed. And those initial reports are also the strongest predictor of who returns to the CPS system, and I think all of us need to collect and keep that data.

So therefore, it is critical for us to retain abuse records and I believe at least until the youngest child of a perpetrator turns 18. So that would be our strong recommendation. Right now we retain records where there is a reason to believe, and our word for it is “verified” or “confirmed,” and then the child is removed for 99 years. But if a case comes in that is closed administratively, and I’m talking about things that are not just an information and referral report, that is expunged in 18 months. So you can imagine cases where there is a pattern, we are not collecting that information and it really is essential.

The other area where there is an obstacle to care and fatalities is that our investigations have increased over the years, and a lot of states’ investigations have increased, but the other parts of the system haven’t kept up. So our family-based safety services, which is our family preservation units, are just overwhelmed. And they are supposed to be visiting and caring for these families that have high risk, where the child is still in the home. And the bottom line is they absolutely need to have lower case loads in order to handle these cases. The CBCAP prevention dollars, I am going to let my colleague, Kathy Fletcher, talk about that. It is federal money that we want to pull down easier. She is looking surprised at me. [laughing]

I want to just briefly talk about what I consider an ideal vision of how we should really be implementing a multi-prong strategy to promote positive parenting and reducing child abuse and neglect fatalities across the lifespan continuum, with a focus on parents of children age zero to three, where 80% of the child fatalities occur.

So if you just got 12:00 on this diagram you would have a universal messaging, much like the Triple P Program across all ages, and helping parents understand not to shake their baby and getting brochures out there in the doctors’ offices.

When you move to 1:00, universal obstetricians teaching moms prenatally about child development. We know that most of the abuse occurs 6 to 9 months during that period of crying that is incessant, and most women have been through that, and also potty training. Zero to three, those are the tough areas and there is unrealistic child development milestones that these parents have. I’ve been on home visits all over the state and it is amazing what parents think is a normal time to be potty trained, one year old! That children can’t hear until they are 6 months old. There is a lot of ignorance out there! We need our obstetricians to be teaching our parents.

Moving to the right of that, at 3:00, we need targeted home visiting programs for our highest risk families, especially during pregnancy. We have talked about the nurse-family partnership briefly. And then, this wonderful program, The Universal Period of PURPLE Crying. It is one of my favorite programs, it is very low cost, and it is a video that you can use in a hospital right at birth! So you’ve got a captive audience, it’s a wonderful program, it teaches parents about that period of PURPLE crying and what to do and not do, and it is very effective.

And then you can go around the continuum at all these different interventions. The solid line denotes a universal program, the striped is targeted, and we have enough information! You could collect data all day long, and I think it is critical, as I mentioned, but I do know that these are the critical ages and we have to do more of a wraparound and essentially, bringing it up to 11:00, universal child development and trauma impact education for junior high and high school kids, including parenting education as a mandate.

The rest of this presentation is more about the results of some of the home visiting programs.

Dr. Sanders: [050:04:55] I believe you sent us your presentation a little late so we don't have it yet in our packets, but everybody will get the PowerPoint.

Petit: [51:00:09] That was an excellent health and human development presentation in terms of how we actually instill in people the ability to protect their children competently and so forth. What is your sense as to whether this has contributed to the reduction in child abuse fatalities in this last year? And is your assessment that it has dropped that amount without anything else factoring in, and that it really is a genuine measureable decline?

McClure: [051:00:36] I wish I could say, Commissioner Petit, that this is due to our wonderful child abuse prevention strategy. We actually spend \$56.8 million in total prevention dollars on a problem that costs us \$7 billion a year. We are spending \$1.25 billion on an agency that protects its children from their parents, but our prevention investment is pitiful. So no, I do not think that is the case, as you can see in this slide. We are only serving about 4% of those at high need of home visiting, and 10% of highest need. It really needs to expand, and we need all funding sources to come together to bring those numbers up. I do believe that the big drop off from our peak of child deaths at 280, it sounds to me like it is very attributable to that more stringent definition of child abuse fatalities that was incorporated in the department, unfortunately.

Dr. Sanders: [051:01:49] We have Dr. Kathleen Fletcher, who is the President of Voices for Children.

Dr. Kathleen Fletcher: [051:01:57] Thank you for having me. This is a very exciting happening on the national level. First, let me do a real quick thing. Our offices are housed at Haven for Hope. It is a fantastic place, a homelessness transformation center. Out of the several thousand people who have come through Haven in the past couple of years, my last information was that at least half of those people had come through the foster care system. So that is obviously not the panacea for most children. And the family-based folks there say that this is the hardest group to work with their children. They have no concept of how to be parents. So we have to find another way of getting to this.

The second thing I'll do for my friend, Madeline, is the CBCAP dollars, at least in this state, are that we have to have one lead agency for those dollars and it is the Department of Family and Protective Services, which is fine, but if there were more flexibility the Department of State Health Services has prevention programs and their

excellent maternal child health evidence-based programs that could come through [inaudible]. And the nurse-family partnership and other programs come through Health and Human Services Commission. So if we had more flexibility of more than one lead agency for CBCAP dollars that would be terrific!

Most of what I was going to say actually has already been said, which is partially because, and this is one of the strengths that I will mention, this is the seventh-largest city in the country! We are not a small town, but we act like it. Pretty much everyone you will see in the next two days all know each other! We know each other, we work together, and we are an exceptional community in terms of working together and collaborating. So that is a real major strength.

I sit on the Child Fatality Review Team, and every month we see, I guess, an average of at least three children with Sudden Infant Death. Then we see another couple of kids who are Sudden Unexplained Death, but it's pending. And it is pending...and it's pending...and it's pending! By the time several months go by...and I'm not a medical doctor so I don't know what goes into that decision, but by the time several months go by it is very hard, particularly if it is the first child in a family, and I'm not going to say "No CPS involvement" but the first CPS involvement, or potential CPS involvement, it is very hard to say and compound that tragedy by calling it a child abuse and neglect death. And one of the things that does, and Judge Specia spoke to a program that will target families who have had a child death, and I know from this state and from the previous one I worked in for many years, Tennessee, if that child is not certified as a child abuse death the child abuse agency cannot then follow with the next pregnancy. They will not be eligible for the program that Judge Specia is talking about if we don't call it a child abuse death. So I think it is very important that we look at that, and we look at it in a timely way.

The other group are the near fatalities, and these are kids who may die several years later, but their lives are going to be truncated. They are not going to live a normal lifespan, and I think that is very important.

The other group I really do want to get to really quickly are the suicides. We are seeing a major increase this year in child and teen suicides in Child Fatality Review. The youngest has been 12. We've just started a subcommittee, and of the 6 or 8 that have been in the past few months one was impulsive and unexpected. The other children tried multiple times to kill themselves and to die. And some of those children are trying to escape child abuse. I consider those child abuse deaths, and I don't know what other communities are doing or other states or doing, but I think we need to look very, very carefully and not just call it a "mental health issue." Where did that mental health issue come from? Many of these kids are severely abused, particularly sexually abused over long periods of time, and attempt suicide beginning at very, very young ages. One I work with, one of the survivors, her first attempts were at 8. That is not terribly uncommon.

One more brief thing, and this is very important to what Madeline said, "universal" is a very, very important concept. We are one of the only civilized, industrialized countries that does not have a universal system of supporting new parents and I think we pay for that in our infant mortality rate and in our child abuse rates.

Dr. Sanders: [052:01:55] Marta Peláez is the President of the Family Violence Prevention Services.

Marta Peláez: [052:02:05] Thank you very much for the invitation and the opportunity to present before you. I will very briefly speak about what the Battered Women and Children's Shelter and Family Violence Prevention Services, its corporate name.

Deaths in Bexar County and across the nation, really, because we have a collaborative arrangement with all shelters and all domestic violence programs throughout the nation to assist.

Eight years ago I made the decision to add the word "children" to what it was, the Battered Women's Shelter, simply because at any time I can very comfortably say that two-thirds of the population that we serve agencywide are children. So much in contrast with what is believed, the majority of the people that are abused and impacted by domestic violence are children, not necessarily women.

Last year, agencywide, we provided services to 45,350 people. Some of these numbers are duplicated numbers from the shelter, the residential program. The increase in the incidence of domestic violence parallels the increase in the incidence of child abuse. Domestic violence and child abuse coexist. Where there are claims of the one it should be known that there is the other. Also note that 68% of the families that arrive at the shelter program have had or have CPS involvement.

Child abuse, like domestic violence, happens in families, therefore the focus of attention should turn to families. Knowing only too well the progressive nature of domestic abuse a claim or a finding of DV in a home where there are children should raise a flag. By the same token, a claim or finding of child abuse should expect to find domestic violence in the same home as well. While it is true that services and help provided to a parent will trickle down to the children, the impact of domestic violence in their lives, given their circumstances, their stage of development and age is distinctly different than that of the adult abused, typically the mother. Consider just the conflict of a 7-year-old boy who is socialized to respect, obey, and follow in the footsteps of his father, who is the same person who abuses and batters his mother. Or the case of three children who witnessed their father butcher their pregnant mother's hands. They tended to her by wrapping her hands in blankets. They pushed the father away from her, while the oldest child called the police. And so on, I could quote more cases that I have here on my paper, but I will defer to your imagination as to what happens to these children.

Traditionally, the categorical nature and the silo-like approach of social dysfunction have kept systems created to intervene and prevent the very problems they seek to address in absurd isolation from each other with dire and fatal consequences for our children. Opening channels of communication between qualified service providers, protective services, law enforcement, the judicial system, the health care providers, schools and churches is paramount. To that effect, at the state level, the 82nd Legislature mandated the creation of a task force in Texas to strengthen the collaboration between domestic violence programs and the Department of Family and Protective Services. Way in advance of the findings and recommendations of the task

force, here in Bexar County the Children's Court and us, Family Violence Prevention Services, were identifying common denominators and elements, drafting prevention initiatives, and enlisting the collaboration of the regional and state CPS officials. The goal was to create bridges of communication, to put at each other's disposal the knowledge, experience, and perspective of our respective fields to identify and address without delay the dysfunction at the core that is in the families.

While there is plenty to be done, and I say it with a certain sense of very limited accomplishment, CPS, the Children's Court, and others involved in the mutual training of our staff, the understanding and the adjusting of investigative protocols so these investigators can go to homes and visit these families and understand the elements of domestic violence so that even if they find nothing wrong with the child that called them to action they can ask the questions, necessary and pertinent questions related to domestic violence.

Dr. Sanders: Thank you. Commissioner Martin.

Martin: [053:02:00] I understand that the child fatalities have gone down in Bexar County in the last year. Have you seen any trend in the domestic violence? You indicated there is parallels between abuse and neglect, and I'm wondering have you seen anything specifically regarding parallels or trends when the fatalities have gone down.

Peláez: [052:02:21] There were 112 women killed in Texas, there were 156 children killed in Texas. The number of fatalities for the children follow that of the fatalities for women, but the abuse, outside of the fatalities, is not the same. So that is on an increase.

Covington: [052:03:00] I feel bad, because I think the issue of domestic violence, family violence, and child abuse and neglect fatalities are some real important connections, and I hope we continue to explore them. So I look forward to your recommendations.

Dr. Sanders: [052:03:17] Vicki Spriggs, who is the CEO of Texas CASA.

Vicki Spriggs: [052:03:20] Thank you, and good afternoon, Commissioners, and thank you for the work that you're doing. I am Vicki Spriggs, I am the CEO of Texas CASA. Are you all familiar with CASA? Anyone not? Good! Then I'll cut to the chase.

We have 71 independent CASA programs across the state. Texas CASA is a membership organization that provides support, funding, training, and technical assistance to each of those 71 programs. In fiscal year 2013, a total number of 7,611 volunteers provided services to 23,621 children in the state's child protective services system. So our CASAs are all over the state providing work in 207 of the state's 254 counties. My testimony today will come from the perspective, clearly, of CASA volunteers. I solicited their input, and these are the things they have asked me to say.

I would like to start, though, by recognizing the work of the hard-working people in the child protective services system. I would also like to commend Commissioner Specia for the changes that he has made since he has been in office, and the support

he has received in the Texas legislature, because some really phenomenal events have occurred in the last couple of years to move the system forward.

Having said that, I would also like to commend all the CASA volunteers, the thousands of CASA volunteers across the state who provide not only their time, their experience, their talent, and their energy, but their funding to help move children safely through the child protective services systems. In Texas, because of the high caseworker turnover, the CASA volunteer, once assigned, is usually the only person to see that child from the start to the finish of their case.

My recommendations, and if you just think about the flip side of what I say, and what works, and what would be needed, we'll tell you what doesn't work.

So what works? A child-focused advocacy works, if we look at things from the perspective of what will benefit the child and not the system. We've kind of gotten into this rut of maintaining and doing things for the sake of the system but the child gets lost in the discussion. We need to always keep the children first!

In line with that, cluster courts. We need more cluster courts across the nation. Cluster court judges spend more time with children, they are better trained on working with children. So I would say more cluster courts would certainly be needed.

Consistency of the assigned worker. And that's a caseworker turnover issue you hear about high caseloads of caseworkers across the nation, let alone in this state. It is something that they are consistently trying to tackle, but every time, and you know this, a caseworker leaves, knowledge walks out the door. The new person comes in, they are slammed with a caseload, and automatically they hit the ground running! What we constantly see are workers who end up becoming CASA staff or volunteers because they are burned out in the child protective services system, because they go in to make a difference and there is too much going on. They don't want to be part of failure or of something bad happening to a child and they stepped out away from the system.

In that line, collaboration with all involved parties. The system works best when people work together across systems. That is the courts, it is law enforcement, it is child protective services, it is CASA.

Culturally responsive interventions, recognizing that one size doesn't fit all. Judge Sakai said it well, "What works well in San Antonio doesn't even work across the state in Houston!" You have to model. You give a model and a framework, and then let people tweak it the way they need to tweak it so it works best for them.

First-hand knowledge of case information data. All too often the guardian ad litem will take, because they have caseloads, the information from someone else and then make it part of their report. The judge thinks they are getting unbiased, well-supported, well-documented information! They don't know it is second hand! So people really need to do their own work.

Dr. Horn: [054:02:47] I should know this, but I don't. What is a cluster court, and how does that work?

Spriggs: [054:02:51] A specialty court. A court that focuses on just family services.

Dr. Sanders: Commissioner Martin.

Martin: [054:02:57] I believe in CASA. I love CASA. Every judge that is currently assigned to Cooke County understands where the CASA is before a GAL almost in my jurisdiction. My question is has there been some correlation between CASAs and child fatalities? So in other words, how many or what percentage of the children who died in Bexar County last year had a CASA appointed to their case, if they had a DCFS case or a court case pending?

Spriggs: [054:03:25] Of the 156 cases where a child died, 14, as Judge Specia said earlier, were in the child protective services system. None of those children had a CASA. In Texas, only 50% of the children have a CASA volunteer assigned. And the difference that makes is when you have a caseworker with eyes on, and then CASA worker coming through also with eyes on, more eyes on is more information for the court to make valid placement decisions.

Dr. Sanders: [054:04:05] Thank you Ms. Spriggs. Joy Hughes Rauls, who is the Executive Director of Children's Advocacy Centers of Texas.

Joy Hughes Rauls: [054:04:15] Good afternoon, my name is Joy Rauls, I'm the Executive Director of Children's Advocacy Centers of Texas. I know you all are very familiar with CACs from your work with Commissioner Bud Cramer, who I believe is at our national conference right now in D.C. Selfishly, I'm a little relieved that I don't have to present on the model before the very man who birthed it for us. But I'm going to try to do it justice for him today.

How things work here in Texas is we have 68 CACs, with the largest network of CACs in the nation here in Texas. CACs provide a number of professional services in the investigation, prosecution, and intervention. A child abuse case includes forensic interviews, trauma-informed mental health to the caregiver and child, coordination and medical assessments, case management, and family advocacy. But at the heart of this entire model is a multidisciplinary, coordinated approach to the investigation, prosecution, and provision of intervention services so that joint investigation between the civil and criminal system to make sure that everybody is sharing information.

CACs were created, really, to be the nonprofit, community-based infrastructure around that MDT to support it! We do a really good job here in Texas. I'm proud to say that we sign MOUs and working protocols with 800 separate law enforcement jurisdictions, over 200 district and county attorney's offices, every CPS region in the state, a number of hospitals, almost every children's hospital in the state, and numerous sexual assault nurse examiners and mental health providers.

I think CACs have long been recognized as a best practice model for moving investigations, prosecution, and intervention services in sexual abuse cases. And I think that is a fair statement. 75% of our 40,000 clients each year are involved in sexual abuse cases. But that is not to say that this model won't work in serious physical abuse cases, as well as cases where a child has witnessed a violent crime or a

homicide. So that remaining 25% of Texas cases are serious physical abuse and neglect and children that have witnessed a violent crime, such as a homicide or domestic violence.

I do think that, in looking at cases that present a higher risk of child maltreatment-related fatalities, that CAC MDTs are a good place to look for coordination and joint investigations that I've heard the task force of the Commission speak about today. Particularly in states like Texas, where we have such a strong infrastructure of CACs across the state. I think an added benefit of bringing these cases, in addition to just sexual abuse cases, through CACs is that we provide trauma-informed mental health to that child and nonoffending caregivers, addressing a lot of those long-term adverse consequences that have come up today.

Two best practices in Texas. We are codified in the Texas Family Code, which was something that happened early on in our inception, and the confidentiality issue about information sharing is well documented in Texas Family Code, Texas 264. And I think if every state could codify and put those things in place for CACs as well as funding, we would have a strong network like this in all 50 states.

Dr. Sanders: Commissioner Petit.

Petit: [055:02:33] Right now are most of your cases child sex abuse cases?

Rauls: [055:02:38] We serve 40,000 children a year and about 75% are.

Petit: [055:02:44] So if I can get clear on this, right now you have MOUs with the different departments. And where are those? Are those codified in law or is that something you drew up yourselves?

Rauls: [055:02:58] Each of the 68 CACs are independent 501(c)3 nonprofits, and in Texas, in order to be a children's advocacy center, call yourself one, or receive state funding, the Texas Family Code says that you have to sign those MOUs and working protocols locally. So each year my organization is the state office for CACs, has the centers apply to us to become a CAC, and they have to show us their interagency agreements and working protocols. So as you can imagine, in Harris County that CAC signs with over 70 law enforcement jurisdictions.

Petit: [055:03:31] So specifically, in terms of fatalities and stopping fatalities, if there was an open CPS case that there has been trouble with the child who is still at home, the mother is getting drug treatment, you are sending people in, CPS is visiting people, and a guy comes in from another state or another county, has a history of domestic violence, has been in and out of prison, would that case be flagged a special case? And how does it come in? Do you check these things every morning, you know, what came across overnight? Is it on a demand basis a week later? What happens? How would you intercept that case or would you intercept that case?

Rauls: [055:04:10] That's a great question. I think a lot of that is dictated by what the MDTs write in their interagency agreements and working protocols as to how cases will come to the CAC and which cases will come to the CAC. I would say that typically the reason we have such a high number of sexual abuse cases is that law enforcement

and CPS, who have to refer kids to us, you can't just bring a child to a CAC, it has to come through an investigative partner, they are bringing that child for that forensic interview, which is the point of intake for us. However, I think local teams could work on what their interagency agreements and protocols are as to how they would intercept those cases. I also think greater visibility for CACs into statewide intake and the impact system that Madeline talked about earlier so that we could see those cases as they are assigned, and facilitating coordination between law enforcement and CPS would greatly help. But right now, to some degree, CACs are flying a little bit blind because we are waiting for CPS or law enforcement to say, "I got a P1 sexual abuse case. I need a forensic interview, let's get it scheduled," and that's what launches the coordination of the joint investigation. So we are working very hard with DFPS to get even further upstream in the process to catch the cases that you are talking about as well.

Dr. Sanders: Commissioner Martin

Martin: [056:00:28] I think that CACs do a fantastic job in Illinois and I know that the sex abuse cases that are investigated through that process seem to get better outcomes in the end. So I think the beginning of the system helps us get better outcomes on the end.

My question is has there been any correlation between the work that you do and child fatalities, since that is what our Commission is designed to talk about? I know you are very successful in the sex abuse cases. Do you see, and do you know how many of your cases or the cases you have investigated been getting results in a child death?

Rauls: [056:01:10] I don't know that we track a case that came through a CAC and received CAC services, and whether or not that prevented a potential fatality. However, we do have a number of centers that their MDTs are working these cases already and on some outcome measurements that we facilitate through surveys the MDT partners have responded, and I think 93% say that MDT process led to a more efficient, effective, and coordinated case investigation. But no, it is not something we have tracked as of yet. We are in a bit of a unique position as that neutral party and that we don't necessarily track our success related to prosecution outcomes, for instance. That is in the hands of investigators and prosecutors, but that would be an interesting data point to have, if a CAC case gets worked through our system does it potentially prevent that long-term outcome.

Dr. Sanders: [056:02:14] Annette Rodriguez, President and CEO of the Children's Shelter.

Annette Rodriguez: [056:02:20] Good afternoon and thank you for the opportunity to testify and thank you for your commitment to children. I'm Annette Rodriguez. I have the pleasure of being the CEO and President of The Children's Shelter here in San Antonio. It is an organization that exists to protect children and strengthen families. We have been doing that since 1901, and annually we serve 4,000 children and families through our programs, both residential programs for children who have been removed because of abuse, abandonment, and neglect, but also almost 1,500 families who are looking for prevention services, so we try to strengthen their families.

I want to talk about three programs. One of them you have heard extensively about is the Nurse-Family Partnership, so I won't go into too much detail, other than we have a program we have been operating since 2009 and it is very effective, it works, and I believe that we should continue to fund programs like Nurse-Family Partnership.

The other program I want to talk about is a fatherhood program. I don't think we have enough focus on fathers in our communities. We run a program called Compadre and Compadre. Judge Sakai made mention of it. We started it in 2009 and we have had tremendous success! Where initially they said, "Here is \$40,000, let's see if you can work with 40 dads." That first year we had a waiting list. Today we are serving over 500 dads every single year. To date, we have served over 1,500 dads, and I'd like to share some statistics. 100% of our fathers commit to parenting without violence when they enter the program. 54% of our dads, when they enter, have had prior involvement with child protective services. To date, all of the dads who have gone through our program, 1,514 fathers, 100% of them have not had re-involvement with child protective services. 100%! 98% of fathers improved their knowledge and attitudes about being a nurturing parent, and 92% of fathers increased the quality time spent with their children.

I want to reiterate the message that we have to use evidence-based programs, programs that are anchored in evidence and research, but we also need to have the flexibility to model programs that fit the demographics of our community, and we have done that with our Compadre and Compadre program.

One of the components about it that I think is the magic of the program is that once our dads go through the 15-week program they are able to re-enter the program as a mentor. They are now trained as a parent, a parent educator, and so they start working with new dads coming in and there is no more powerful message than someone who has already walked that walk. And in addition to that, our parent mentors are also responsible for being involved in the community and providing community service. Our fathers have given countless hours to the Food Bank, to Habitat for Humanity, and other city initiatives that we are very proud of.

The last program I'd like to talk about is the respite program. We have a program called I-Parent San Antonio, and it provides respite relief to parents. We are the only program in San Antonio that does that, and only one of two in the state of Texas. We have served over 1,000 parents in our I-Parent Program and 500 of those have been served through our respite program, and I'd like to share some statistics with you. Of the families served, 100% of them have not been involved in child protective services. 95% of children have been developmentally on target. 85% of parents have demonstrated improved parenting skills and knowledge, and 100% of parents state that the crisis has been eliminated or is manageable.

One of the things that we have found with our respite program is we offer them up to three days of respite. So this is for parents who are at the end of their rope and need additional resources, need help! What we have found is they don't normally need three nights of overnight respite for their children, they just need a couple of hours. They just need a couple of hours to spend with your parent educator who can then work out a plan, and they walk out of the office feeling confident because they know that they have a professional who is going to work with them for at least 7 weeks to

help them get over whatever crisis they need. It is making a difference and I believe we need to put more money into prevention, we need to put more money into programs that are being effective, and we need to look at growing them and making them go to scale so that we are able to be much more effective and widespread.

Dr. Sanders: Commissioner Zimmerman.

Zimmerman: [057:01:45] Yes, I have a question. Could describe how you are measuring the quality of engagement that the fathers are stating? How are you measuring that?

Rodriguez: [057:01:56] We use the Nurturing Fathers Program by Mark Perlman. Part of the assessment there that is part of that program is the AAPI, Adult and Adolescent Parenting Index, so we do a pre and post. So when they come in they receive the pretest; at 15 weeks, at completion, they receive the post, and that is how we receive those outcomes.

Zimmerman: [057:02:22] So can you describe what some of the indicators are?

Rodriguez: [057:02:25] Absolutely! We look at one as anger management. We also look at quality time spent with the children. We also do reflective practices so they are able to reflect back on how they were parented. They talk through what they experienced, and we are able to then, within the context of the program, create a new narrative for them and their children.

Dr. Horn: [057:02:56] First, I want to commend you. You covered three programs very quickly! On the fatherhood program, how do you recruit fathers? Unless it is true, I don't want to leave the impression that all of them are coming from referrals through the CPS system.

Rodriguez: [057:03:15] As the judge mentioned, parents will go through Drug Court, or they'll go through the Children's Court. Some of them are mandated, actually, many of them are mandated to go through the program. It is about half-and-half, 50% of the other half come from word-of-mouth and also just self-referral.

Dr. Horn: [057:03:36] So the number that are coming through CPS, which is the focus of this Commission, would be what percentage?

Rodriguez: [057:03:42] About 50%.

Dr. Horn: [057:03:46] 50% through CPS. And you have 100%?

Rodriguez: [057:03:50] Yes, 100% of the families or the fathers that we have served have not gotten re-involved with CPS, and actually many of them have regained their visitation rights to their children and/or have received custody rights to their children.

Dr. Horn: [057:04:00] That is very impressive. The only thing I can say with 100% certainty is I'm not going to get a full head of hair! [laughing]

Dr. Rubin: [057:04:10] Yes, these were some really impressive statistics and programs. I think whether it is the domestic violence program, CAC, your program, other programs, CASA programs we heard about today, we get the picture, and I think this is something we probably need to talk about as a Commission. In a situation with limited resources, you come to the local community level, and it is not any different in Philadelphia, it is the same thing. You find these tremendous programs all trying to bite off a piece of what is a huge magnitude of risk. And the question that I often find myself wondering is who selects into these programs and how do the programs and the community start to structure a continuum of services together so that, just as you mentioned those fathers who came in, were they self-selected in? You know, some places will target child welfare-involved families. You have programs that are even more on the primary prevention side. But I think it is more of a question of how can communities organize the approach to recruitment when they don't have enough resources to meet the needs.

Rodriguez: [058:00:22] Yes, if I had the answer to that it would be wonderful! But one of the beautiful things in San Antonio is I do feel like many of the providers and nonprofits are very collaborative. We work with one another, we refer to one another, but again there is so much work to be done that the statistics that I stated, I mean that is still just a drop in the bucket. There is still a lot more to be done and we need a lot more resources.

Dr. Sanders: Commissioner Ayoub.

Ayoub: [058:00:46] On your respite program is that one time for that parent or can they come back again, like a couple of others mentioned with the other programs? How do you get these people? Are they coming in through an agency or themselves?

Rodriguez: [058:01:05] We do a lot of community outreach. Now the other recommendation that I would make for the respite program, it is funded by the state, it is part of the CBCAP monies, but one of my only criticisms of that funding is that we are not allowed to work with families who have had prior CPS involvement and/or currently have an open CPS case. And I would argue that is probably one of the most vulnerable populations that should be served. And so we are doing true prevention but we're being limited in who we can work with. So I would say that we open up the flexibility, open up the floodgates and let's work with those families who are truly vulnerable, who are in need.

But to your question, where do they come from? They come from all over the community. They may be referred from a partner organization that is working with this family and realizes they need help, or it may be just a family or a family member who realizes and sees that this family is overwhelmed or that they, themselves, are overwhelmed and they reach out to us. At the Children's Shelter, one of our services is sheltering children who have been removed for abuse, abandonment, and neglect, and I can't tell you the number of parents who have come over the years, and especially in the last three years, who have come to our doors with children and a bag and say, "I can't take this anymore. I'm overwhelmed. Before I do something stupid..." What they don't realize is that by doing that they are now inviting the justice system and legal system, and it often takes years for them to be able to rectify that action. And so respite allows for that breather, and sometimes that is all these parents need is the

time, just a couple of hours, to step back, to breathe and reflect on what is going on, to talk to a professional so that they can see that their crisis is not insurmountable, it is not just happening to them, and it is not something that is going to be with them for the rest of their lives, it is something that they can work through. And once they see that light at the end of the tunnel everything changes and they are able to be parents again.

Ayoub: [058:03:04] Is there a limit on that?

Rodriguez: [058:03:06] Up to three times.

Dr. Sanders: Commissioner Bevan.

Dr. Bevan: [058:03:10] I had a couple of questions in terms of eligibility for your program, but then you brought up flexibility. So you are the third person who has brought up flexibility in terms of funding. And I guess I want to know what you mean by “flexibility.”

Rodriguez: [058:03:28] For the purpose of this testimony, in terms of providing prevention services. So giving us the flexibility of who we can serve. So if a family comes to us, and whether they have an open case or whether they’ve had prior CPS involvement, if they need help, they need help and I need to be able to help them.

Dr. Bevan: [058:03:46] Right. So you want flexibility in terms of being able to use service dollars.

Rodriguez: [058:03:52] Correct.

Dr. Sanders: [058:03:58] And our final speakers are Dr. Lisa Pion-Berlin and Dakotah Hickle.

Dr. Lisa Pion-Berlin: [058:04:10] Good afternoon. Thank you for having us today. We are here to talk about prevention. Parents Anonymous is the oldest child abuse prevention family organization in America. We serve families before things occur, when things occur, it doesn’t matter to us. People come to our evidence-based support groups and we serve the entire family. So we have an adult group, a children’s program, and in our greater wisdom years ago we started a national parent help line. Actually, the Congress gave us some money and then said, “Go fuel that yourselves.” So we are here talking about that prevention does work. Evidence-based programs like ours need to go up to scale to be everywhere. The message needs to be asking for help is a sign of strength, which is not just a slogan for Parents Anonymous but for parents like Dakotah.

People need to feel that they can reach out and ask for help no matter, nowhere, no how, wherever they need to, and I think we need to be there to embrace that to prevent fatalities and to prevent the next incident or occurrence.

We talk about trauma-informed practice, we talk about ACES [the Adverse Childhood Experiences Study], we have all this information. We know where the future lies. We need to be here for families. And we do it in a very unique way; we build upon

people's strengths. So they are parent leaders who are doing all kinds of work all over the country and giving back on federal Commissions and testifying. The founding mother of Parents Anonymous testified to pass CAPTA in 2008. Parents Anonymous parents testified to reauthorize CAPTA. Whatever those messages are we need to not only help to strengthen families but give them leadership opportunities to create change. We cannot make those solutions ourselves without doing it in shared leadership.

Without further ado, I'd like to introduce Dakotah Hickle from San Antonio, Texas.

Dakotah Hickle: [059:01:00] San Angelo, Texas. I'm honored to be here with you all to share my personal journey in health, support, strength, and hope. God has blessed me with three beautiful little girls: Justice, who is 5, Jasmine is 3, and Jewel is 2. Over the past 3½ years I'm taking control of my life and have made a commitment to transform myself to be the best mom I can be, thanks to evidence-based Parents Anonymous weekly support groups.

Reality for me came knocking on December 2nd, 2010, when I was arrested and started serving time for drug possession. I was charged with child endangerment, and my kids were taken and put into foster care. I was shaken to my core. And I realized I needed to change because my kids needed and deserved a loving and nurturing mom. My heart ached for my two kids in foster care. And then I found out I was pregnant with my third child, Jewel, and I began my sobriety December 23rd, 2010. I prayed every day for God to give me a second chance. On February 3rd, 2011, I was released on 7 years probation but ordered to inpatient drug treatment. I was successful, because I committed to dealing with all my demons for their sake and to change our lives forever for the sake of two little girls in foster care and my unborn child. When I moved back to San Angelo with my newborn daughter, Jewel, I knew I needed help, and needed it quick! And luckily, I began attending Parents Anonymous in my hometown every week for the next 7 months. Going into my first meeting I felt scared and ashamed, but with mutual support I reached out to other parents, I received much in return, and I worked hard to create positive change in myself. I felt welcomed and encouraged, and I knew I wasn't alone anymore because they believed in me! They believed in my ability to be a good parent. I shared my challenges, my fears, my successes, and we started creating solutions that worked for me and my kids. And today I also call the National Parent Help Line to reach out, to strategize parenting issues, and to know that I'm not alone. During these times my family, my mom and dad, both in recovery, stood by my side the whole time, and my mom was able to see me become a positive parent before she passed away in 2013. So I'll never forget the day that came, April 13th, 2012, a year and a half later, my kids finally got to come home. We were reunited as a family and together we all went to Parents Anonymous to deal with the transition, to allow my girls to deal with their anger towards me, and to get used to the new mom I had become. United with their father, we have built a solid foundation of our nurturing and loving family.

Parents Anonymous provided me with unwavering support and opportunity to grow as a community leader and make amends to my children. Today I remodel houses to support my family. I am active in my church. I'm bilingual in Spanish. I've taken courses at Angelo State University, and I want to make a career to help other parents like myself to prevent child abuse and neglect, personal suffering, and ultimately,

child fatalities. I share my story to put a human face on this subject. I am one of thousands of Parents Anonymous parent leaders trying to make a difference by ensuring better outcomes for their families. It is my sincere hope to inspire others to seek help and support early, and that this Commission will advocate for prevention resources to support Parents Anonymous programs and the National Parent Help Line nationwide and here in Texas. Thank you.

Dr. Sanders: Thank you very much. Any questions or comments? Commissioner Martin.

Martin: [060:00:06] We are all very, very, very proud of you! And we congratulate and you and your family. My question is although you are well on your way and developing a strong and healthy family, prior to you going into jail had you tried rehab before? Had you tried treatment before?

Hickle: [060:00:29] No ma'am. It was the first time.

End of Day 1

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Dr. Sanders: [061:00:01] ... She probably has as strong a history and knowledge of child welfare policy as anybody in the country, and we are very fortunate to have her here and she will be followed by a panel of medical experts talking about practice in Texas, and will give us a good sense of how things are counted, what the service system looks like, and how the state is performing related to child fatalities.

I will ask the Commissioners again to just introduce themselves for those who are listening as well as those who are here and might not have been here yesterday. Dr. Rubin, do you want to start?

Dr. Rubin: [061:00:36] Yes, I am Dave Rubin, I'm a general pediatrician from the Children's Hospital of Philadelphia and I co-direct a center called Policy Lab there.

Ayoub: [061:00:44] I am Amy Ayoub from Las Vegas, child advocate.

Dr. Horn: [061:00:50] Wade Horn from Deloitte Consulting.

Martin: [061:00:54] My name is Patricia Martin and I am the Presiding Judge of the Child Protection Division in Cook County, which is Chicago, Illinois.

Dr. Sanders: [061:01:00] David Sanders, and I'm Chairman of the Commission and a Vice President at Casey Family Programs.

Dr. Bevan: [061:01:10] Cassie Statuto Bevan, I have 20 years experience on Capitol Hill and worked on most of these programs.

Covington: [061:01:18] I'm Teri Covington, I'm the Director of the National Center for the Review and Prevention of Child Deaths, and I support state child death review programs and their work.

Petit: [061:01:28] I'm Michael Petit, the President of the Every Child Matters Education Fund, and formerly the Commissioner of Health and Human Services in the state of Maine.

Zimmerman: [061:01:34] My name is Marilyn Zimmerman, and I'm an enrolled member of the Fort Peck Assiniboine and Sioux tribes. I currently serve as the Director of the National Native Children's Trauma Center at the University of Montana.

Dr. Sanders: [061:01:49] And again, similar to yesterday, we have a number of people who are joining us from the public here and on the phone. And we have our website that was just launched, and so for those of you both here and on the phone, if you want to make comments you can do them in writing on our website. And the website is at EliminateChildAbuseFatalities.site.usa.gov. And you can send us comments through the contact section of the site.

We are ready to get started with Emilie Stoltzfus, with the Congressional Research Service.

Emilie Stoltzfus: [031:02:10] Good morning everyone. I have a long time slot this morning, and I hope not to be slaving through my thousands of slides the entire time. I hope that you will want to ask questions and if at least I get through the programs then we can go from there.

Anyway, my name is Emilie Stoltzfus, as Chairman Sanders said, and I work for the Congressional Research Service, which is part of the federal legislative branch. And our responsibility to Congress is to provide them with nonpartisan policy analysis and information. So I understand my task today as giving you sort of a lay of the land with regard to current federal child welfare policy, programs, and funding, and I have a lot of slides. I am not going to read all the words on them, we will try to get through what we can, and we'll talk as well.

What I plan to do first is give a few opening thoughts about the overall topic and then focus a little on the issue of responsibility for child protection before turning to an overview of federal child welfare programs, then diving in a little deeper into the programs which have the most federal requirements attached to them for states with regard to child protection and child welfare. I'll also discuss some of the more general purpose grants, which states use to fund their child welfare programs. And after highlighting a few additional programs that are outside of child welfare, I wanted to close with a discussion of some of the things that we know about children and families who come into contact with the child welfare agency.

So on opening, a primary responsibility of child welfare agencies is to identify and serve families where children's safety is most at risk. Those are families with the greatest need, and some say "dysfunction." I say that even though the purposes of some federal child welfare programs are much broader, and I'm thinking especially of the Child Welfare Services program and title-IV-B, which encompasses concern for the well-being of all children and their families. But even so, the role of public child welfare agencies is generally more narrow, in the first case because the resources are limited. And so child welfare agencies necessarily have to target their work, and in the second case because many people see the role of a public child welfare agency in private family lives as somewhat limited and should be limited to only families in which there is a concern for the safety of children.

The federal role in child protection has some limits and it has sometimes been contested about what the limits are in terms of states and the federal role. With the enactment of the 1997 Adoption and Safe Families Act, Congress clearly did articulate safety as a paramount concern of federal child welfare policy and all child welfare decision making. At the same time, federal funding available to states to meet the goal of safety is provided to allow states to remove children from unsafe homes and place them in foster care, as well as to provide assistance to children who leave foster care for permanent adoptive families. That is what most federal money is provided for. Federal support to child welfare agencies for other kinds of services, including those to identify families where children are at risk and to strengthen those families is a much more limited pot of money.

And finally, I think it is fair to say that the explicit focus of federal child welfare policy on child abuse and neglect fatalities is fairly limited.

So I start, and this is my historian roots showing, with some overview of child welfare legislation and sort of how we got here. So the next four slides I'm going to cover are mostly focusing on the first slide. To provide a highly selective chronology of some child welfare-related programs and the Protect Our Kids Act, which created this Commission, called in part for a study of the effectiveness of child protective and child welfare services that are funded under title IV and title XX of the Social Security Act, and so I want to talk about where those programs came from and how they are connected. It doesn't talk about CAPTA. That is likely due to a committee jurisdiction issue that the committee had. In any case, CAPTAs can't be left out, so we'll also talk about CAPTA. And I've also tried to highlight some other legislation that is important.

So turning to the beginning of this chronology, in 1912 Congress established the Children's Bureau. And the Children's Bureau is the agency now in federal government that actually administers most federal child welfare programs, and those are the child welfare programs that send money to states and make federal requirements of them. The [Children's] Bureau was actually authorized with a quite broad mandate, and maybe it is instructive to know that the first thing it worked on was the issue of infant mortality. In fact, documenting why children died, why infants died, and insisting on birth certificates for every child. In any case, the role of the Children's Bureau now is more constrained and is about the federal child welfare programs that we talk about today.

In 1935, the Children's Bureau was instrumental in writing and having included in the original Social Security Act two titles. Title IV was the grants to states for age-dependent children, and title V was grants to states for maternal and child welfare. Under the title IV program, states could receive federal reimbursement for part of the costs of providing financial assistance to each needy child, and under title V there were three grants authorized, one for maternal and child health, one for what were called crippled children's services, and the third for child welfare services. And those are basically the forerunners of today's title IV, Temporary Assistance to Needy Families program; title IV-B, Child Welfare Services Program; and the title V Maternal and Child Health Block Grant.

In 1956, Congress amended title IV to allow states to provide social services to ADC families, and that was toward the end of rehabilitating those families and ending their dependence, and that is the earliest roots of the title XX Social Services Block Grant that we have today.

In 1961, Congress also amended the ADC program to allow ADC assistance to follow a child from his or her home to a foster family home. This action followed a series of events that began when child welfare advocates noticed that Louisiana had reduced their ADC caseload virtually overnight by some 22,000 children by placing legislation characterizing the homes of these children as unsuitable because of out-of-wedlock births that occurred in the homes. And further examination of state practice found that Louisiana was not alone in this practice, and the federal agency that administered ADC stepped in and issued a rule that said states must continue ADC assistance during the time that the state makes the effort to either improve the home conditions or make arrangements for the child elsewhere. The federal agency said that the states' failure to do this would mean a loss of their ADC funds. So states responded the way states do, and Congress responded to states by actually giving them more time to

meet the requirement and also amending ADC to allow money to follow children from ADC to foster care, and it also stipulated at that time that federal assistance would only be available if a judge determined that the home was contrary to the welfare of the child and further that the home where the child was placed was a licensed foster family home. So that provision was initially temporary; it became permanent in 1967, and in 1980 Congress created the title IV-E program that we know today as the federal foster care program.

So moving along, we get Medicaid in 1965. Child Welfare Services moved to Title IV-B in 1967, and in 1974 Congress enacted the Child Abuse Prevention and Treatment Act. That was following several significant things that happened in the 1960s; there was the publication of the Battered Child Syndrome, more attention to child abuse and neglect at state levels, the federal Children's Bureau actually released some model statutes around receiving and reporting child abuse and neglect, and many states had started to act on that.

The initial idea in CAPTA, which was introduced by Senator Mondale, was to actually amend the Child Welfare Services program to require child abuse reporting, receiving and responding to reports there. I think there was some committee jurisdiction issues. Senator Mondale served on what we now call the HELP Committee. In the end, the legislation that emerged came out of the HELP Committee and it authorized primarily funding for a federal focus on child abuse and neglect issues, a federal office around that, research money, and additionally a small amount of money to states for them to improve their child protective services.

1974 was also when Congress created title XX, moving that social services funding stream from IV to a separate title XX, and in 1980, as I said, they created the independent Foster Care Program. When they did that, they also provided funds to states for adoption assistance, children leaving foster care to adoption, and further, they also sought to strengthen protections for children, particularly children in foster care, by tying incentive funds to child welfare services. You could get more child welfare services funding if you provided better protections to children in foster care.

In 1981, title XX was rewritten as the Social Services Block Grant. The 1980 law that created title IV-E had also actually increased funding for the Social Services Block Grant, or actually what was called Social Services, then title XX, and with a thought, I believe, toward that being resources for child welfare agencies. In 1981, however, there was a block grant made out of the Social Services Block Grant and the funding was reduced.

In 1984, Congress created something called the Crime Victims Fund, and this is a fund that collects criminal fees that are owed to the federal government. It is administered by the Department of Justice, and most of the money is sent to states on a formula basis for them to provide victim assistance, and included in that is child abuse victims and victim compensation. In 1984, I don't have it here, but Congress also created the Family Violence Prevention Services Act.

In 1988, I think as was mentioned the meeting yesterday, Congress, as part of its reauthorization of CAPTA, created the Presidential Commission on Child and Youth Deaths, however that Commission was not funded, and so never acted.

In 1990, Congress created the Victims of Child Abuse Act. This is the only set of programs that I'm talking about that are actually administered outside of HHS. They are administered by the Department of Justice and that law authorized funds for training for judges. And some of you may know that as the model court program that the National Council of Juvenile and Family Court Judges do. It also authorizes funds for court-appointed special advocates and for children's advocacy centers.

In 1993, Congress made probably the biggest change to IV-B since it had been created. It established funding for family support and family preservation, a new formula grant program to states. And at the time, there was a lot of optimism about the use of intensive family preservation services to keep families together and prevent children from needing to enter foster care, and this is one of the reasons that Congress acted at that time.

In 1992, citing as part of the CAPTA reauthorization the failure of there to be any funding for the Commission, Congress instructed that the advisory board on child abuse and neglect, which was then a mandated advisory board under CAPTA, was to examine maltreatment-related deaths of children and youth, and that resulted in the 1995 report known as *A Nation's Shame*.

In 1992, also as part of that reauthorization of CAPTA, Congress amended something called the Children's Justice Act program, which provides grants to states and required them to focus on improving their handling of child abuse and neglect fatalities.

In 1996, as part of welfare reform, Congress repealed the Aid to Families with Dependent Children program and replaced it with Temporary Assistance for Needy Families. In the 1996 reauthorization of CAPTA a lot of changes were made to the law, and one of the things that HHS drew from the changes was that it was to have a smaller role in overseeing state compliance with CAPTA requirements, and it gave states guidance saying that it would, in fact, investigate or look into issues if the issue came to its attention, but it would rely on state governors assuring the HHS that it was in compliance in terms of oversight.

In 1997, Congress enacted the Adoption and Safe Families Act with the great focus on an interest in safety of children, including around termination of parental rights.

And finally, on the last page, the long trip through history here, I want to just mostly focus here. I think in the first items that I pointed out, Congress is really focused on safety, and well-being, and permanence for children in foster care.

In 2010, Congress funded the Maternal, Infant, and Early Childhood Home Visiting Program. It established that as part of title V. Home visiting is an evidence-based program. Congress said that to get this money, the state had to spend at least 75% of the home visiting funds on evidence-based programs.

In 2011, and I think this came up yesterday, Congress amended the Child Welfare Services Act to require states, as part of their plan, to provide more comprehensive data on child abuse and neglect related fatalities, and it asked states to describe the

information they used, why they didn't use certain information, if they didn't, and to talk about how they would include that information.

In 2012, Congress passed the legislation that created this Commission, and most recently Congress has required the Attorney General to report on state penalties for child abuse. Including whether there are enhanced penalties when victims suffer serious bodily injury or permanent or protracted loss or impairment of mental or emotional function. That was just signed into law last month by the president.

So does anyone have questions?

Dr. Bevan: [065:00:30] What was the number of that one?

Stoltzfus: [065:00:36] It's the Kilah Davenport Act and it is 113-204, maybe.

Ayoub: [065:00:53] On the home visiting program you said it is evidence-based. Could you explain to me, is that evidence that it prevents fatalities?

Stoltzfus: [065:01:03] No. Well, it can be. Home visiting programs are aimed to achieve multiple purposes. One of them is to reduce abuse and neglect and also, as specifically stated in the legislation, to reduce injuries to children. Another is to improve their school readiness. Another is to improve the health of the mother and the child. And another is to improve parenting skills. So each model may focus on one or more of those issues and some of them have more evidence around sort of the child maltreatment-related or improved parenting than others. But I do believe that the legislation specifically calls for states, as part of setting benchmarks, to look at a possibility that one of the benchmarks they can set is around the number of injuries to children. That's how it is described.

Dr. Rubin: [065:02:15] That was great Emilie. My question has to do with you see the sequential, institutional memory in terms of how we created a long line of acts in child welfare, and nibbling at the edges is health and other systems such as IDEA, Medicaid, EPSDT. I think one of our challenges as a Commission is to figure out how kids slip through the cracks. And often, in my experience, it is because we tend to focus on child welfare and we kind of give Medicaid and other programs, WIC, child care or early childhood education, or early intervention a free pass from this discussion. When there are potential touch points where we see kids earlier in their life, for example, the fostering connections with coordinating health care for children in foster care. Well it is just foster care, and there was no definition of what that even meant, right?

Is there anywhere in the process where, as part of the CFSR process, states are required to talk about how they actually coordinate their programs at the Medicaid office and with early childhood pediatric care? Is there any examples of where that has been institutionalized to create a cross-walk?

Stoltzfus: [065:03:35] So one of the difficulties is that Congress makes requirements and we talk about the states. And they are attached to specific pots of money that go to specific agencies. So the requirements that are in title IV-B and title IV-E, these child welfare requirements, that is money that goes to the state child

welfare agency. So the Medicaid agency, not so much. I mean even though the law says that the state is required to have this Health Oversight Plan, and that it is required to consult with a Medicaid agency, unless Congress would actually amend the Medicaid statute and say, "Medicaid agency, you must do this," that may draw the attention of the Medicaid agency, but the dollars that are on the hook, the accountability, the review, like CFSR, is of the state child welfare agency. It is not in general the state as a whole, and in the CFSR they do look at service array, and coordination, and so it is not as if they are not asking the child welfare agency if they are doing these jobs of coordination and talking about whether there is child care available, and that kind of thing. But they are only asking the child welfare agency because that is where the compliance is on that program.

Dr. Rubin: [066:00:03] That is one of the things that we could talk about, and I think I put this on the agenda for the Commission, is we need to start digging into Medicaid a little bit. Because more than half of these kids who are dying of child abuse and neglect, they are not known to child welfare, but they are known, I believe, to Medicaid, or most of them are. And so maybe you can help us think about what that path would look like if we started thinking about responsibility of Medicaid programs in terms of population health and in terms of actively sort of thinking about kids who are slipping through the cracks.

Petit: [066:00:40] I just note that virtually all of these federal programs almost never go to individuals directly, they go through state agencies. And the state agency, and we heard the Commissioner yesterday, and when I was Commissioner of Health and Human Services in Maine, it included WIC, EPSDT, Medicaid, Child Welfare, IV-E, IV-B, IV-A, Social Services Block Grant, all of it was under the jurisdiction of a single state agency. And in working with the governor, and working with the legislature, we had tremendous latitude in how to coordinate all that, what the funding levels were that were approved, etcetera. So there is! If the state chooses to exercise greater collaboration and coordination, it can! But there is also something that has to happen at the federal level, and at the federal level right now, my own view of it is that it is a very weak oversight function of the states on this and that there is just a lot of freelancing that is going on, and it is an accident of geography as to whether you are more likely to be protected or served in one state than the other, whether it is infant mortality rates and whether it is child fatalities.

I would note, by the way, that with the onset of the Children's Bureau, back 100 years ago, the initial focus was on infant health and child mortality. And it is interesting to me to note that the infant mortality rate, that was about 160 per 1,000, today it is about 6 per 1,000 live births, and there is a direct line to the federal government in terms of how it happened that we've got such a low infant mortality rate across the country. There is still differences amongst it, but you could go through every one of those acts, and if you were measuring the well-being and improvement of children's lives and families lives you could see there is a steady trail for 100 years of that happening. And then there is some question about today as to what it is that we are doing, and one of the things I would note to people is that many of those programs started out as cash entitlements to the states, and then they were converted to block grants, which greatly weakened the ability of the states to serve people.

Dr. Rubin: [066:02:42] I think at the federal level we can incentivize states who want to do the right thing, and we reward those states for beginning to really dictate their programs. And I do believe there is a greater capacity for the states to do it, but without that incentive their minds race in a hundred different directions. And so even, for example, the Fostering Connections Act that focused on education led to a whole bunch of innovation in terms of local jurisdictions really starting to think about how to improve educational stability for youth in the system. And I think we need the same kind of push to think about how we are coordinating around health and well-being for children that we haven't seen and actually could encompass the issue we are here for today.

Petit: [066:03:30] And just one rejoinder to that on this specific piece is that in the end what we are going to be forced to deal with is are these kids American kids first, or are they Texas kids first, or are they Maine kids first, or are they Pennsylvania kids first? That is a fundamental question on all of these things.

So we can hear what we heard yesterday, which was very many terrific programs, the issue is always "scale." Is it up to scale? Or is it 2% of the population, or 10%, or 95%? So we will go to every jurisdiction and hear about great programs, the question is going to be how many are being left behind on this thing? And I don't know if you guys maintain data as to how deeply penetrating these programs are into the actual scope of the problem.

Dr. Sanders: Commissioner Bevan.

Dr. Bevan: [066:04:04] Emilie, you always make me feel like a fraud! You are such an expert, and I've known you for 25 years. But I want to comment on the fact about incentives. The current incentive, and correct me if I'm wrong, is to keep kids in beds. I mean we are funding foster care beds! We are funding IV-E on an open-end entitlement basis, which means that we are spending uncapped entitlement funds for every kid that goes into foster care. And as the number of foster care children drops, the amount of money that states receive drops. Yet the money for services is capped, and we spend billions on beds for maintenance for children in foster care under IV-E. Billions! But we spend millions on services.

Stoltzfus: [067:00:02] Right. Yeah, I'm going to talk about that.

Dr. Bevan: [067:00:05] So the incentives are in the wrong direction. They are there, but they are in the wrong direction.

Stoltzfus: [067:00:09] The incentive is for foster care.

Dr. Sanders: Commissioner Horn.

Dr. Horn: [067:00:13] Because I think it is an important point, I just want to emphasize this connection between Health and Child Welfare. So for those who aren't aware, the Maternal Child Health Grants were once part of the Children's Bureau, and administered by the Children's Bureau. And then we separated it out, which I always thought was a very, very, very bad thing to have done, because it said the Children's Bureau was going to be about child welfare and not about the health of children,

despite, as you've said, Michael, the extraordinary history of impact of the Children's Bureau on infant mortality.

The other thing, though, is there is another moment that in time now I think we can start to utilize to drive this better connection. It is that Medicaid has primarily been, for much of its history, a fee-for-service payment system. So it is basically just you get Medicaid, you go to a doctor, see a hospital, send a bill, we pay it. As we've moved to managed care I think there is an opportunity to start to actually manage the care of the kids. And so I don't think we should lose sight of that as an opportunity in this Commission as well.

Dr. Rubin: [067:01:26] It is an incredible opportunity, I totally agree.

Dr. Sanders : [067:01:30] Emilie, I have a question. You've mentioned several times the issues of committee of jurisdiction. And can you speak a little to that? What House committee has responsibility for CAPTA? And can you also tie it to Wade's question, or his comment, or maybe, Wade, you can, that decision about moving title V, is that an administrative decision or a legislative decision?

Stoltzfus: [067:01:59] That was in the administration, yes. So the decision was to put the Maternal and Child Health Bureau was created in 1990, I think, or something like that, and placed in the Health Resources Services Administration of HHS. Before that, it was still with the Children's Bureau. And committee jurisdiction in the House for CAPTA is Education and the Workforce Committee. And in the Senate, it is the Health, Education, and Labor.

And another one of the issues on health is, and this is a tricky one, in the Senate the Finance Committee has responsibility for both the child welfare programs that we talked about as well as the Medicaid programs, as well as Title V. So they can actually act on all of those things. In the House, the Ways and Means Committee has jurisdiction of the child welfare programs, the Energy and Commerce Committee has jurisdiction of the Medicaid and Title V programs. And getting committees to work together...is like maybe there should be perhaps lessons about collaboration among committees or something. It doesn't happen very often! It's hard.

Dr. Horn: [067:03:20] Since we're talking history, just one point the people may not know. Originally, the Chief of the Children's Bureau was a direct report to the President of the United States. And today, if you are Chief of the Children's Bureau, and I once held that title, you report to the Commissioner for the Administration on Children, Youth and Families, who reports to the Assistant Secretary for the Administration for Children and Families, who reports to the Secretary of HHS, who reports to the President. And so if you start to think about that devolution of a direct line of reporting to the President it says something about our nation's commitment to child welfare and to the well-being of children.

Stoltzfus: [067:04:04] Okay, so I wanted to talk a little bit about responsibility for child protection. Generally parents have the responsibility of care and to provide for their children, and a fundamental right to make decisions concerning their care, custody, and control. Further, the presumption of society is that parents will in fact act in the best interests of their children. However, when parents or other caretakers

do not do this the need for public intervention is determined primarily at the state and local level. And that is because matters related to family law as well as criminal law reside most broadly with the states. The states, and this is under the Constitution, retain a general police power to regulate health, safety, and welfare of their citizens. By contrast, Congress acts within its enumerated powers, for example, in the areas of commerce, spending, taxing citizenship, and its power to legislate for federal enclaves.

So consequently, the child welfare system that we talked about yesterday is really a state and local run function. However, the federal government has asserted a long-standing interest, as we just talked about, in child welfare and it requires states, by the power of its purse, by giving states money, to meet certain standards or certain requirements. So for example, in CAPTA it says, "You have to at least have this level of a definition of child abuse and neglect in order to get these funds," and there is lots of examples of that in child welfare.

So I'm actually going to now give a little bit of an overview of federal child welfare programs, goals, and their funding. We talk about three primary goals in federal child welfare policy: Ensuring children do not experience or re-experience abuse or neglect is a primary goal, and we talk about that goal as "safety." Making sure that families are strong and able to nurture their children's development no matter where the children are living; foster care, and at home. They should enjoy healthy, physical, mental, social, and educational development. That is expressed as a goal of well-being.

And finally, some children must enter foster care for their own safety. This is considered a temporary living arrangement, and the goal is to ensure permanence by reuniting the child with their family or, if that is not possible, finding a new home for the child via adoption, guardianship, or living in the home of a fit and willing relative.

Federal child welfare funding dedicated to child welfare purposes may be spent on a wide range of activities, and I've listed a lot of those on the side of the slide there. And they can spend for children whether they are in their own homes or in a foster family home or adoptive home. Federal policy also requires child welfare agencies to ensure children's safety in their own homes and to make reasonable efforts to reunite children with their families, in most cases. However, as Cassie has already mentioned, most federal funding dedicated to child welfare purposes is provided for children once they have been removed from their homes. So there are a lot of activities authorized, but the funding is primarily about foster care.

And this is my attempt at a one-page snapshot of federal child welfare policy. So when I talk about programs dedicated to child welfare, I'm primarily talking about programs authorized in title IV-B and title IV-E of the Social Security Act, as well as those that are included in CAPTA. And most of these funds authorized under those parts of the law are distributed to state child welfare agencies and they are conditioned on states meeting specific child protection and child welfare-related requirements.

Title IV-B authorizes two formula grants providing funds to states for child welfare and related services to children and families. It also has some research and technical assistance money in there. It got \$674 million in 2014 funding.

Title IV-E primarily provides reimbursement to states to cover a part of their cost of providing foster care, adoption assistance, and at the state's option, kinship guardianship assistance to children who are determined eligible under the federal eligibility criteria. Funding for those purposes was most of the title IV-E funding, about \$6.9 billion in 2014 budget authority. Additional title IV-E funding is for services to youth aging out, \$183 million in 2014, and for adoption incentives, which is incentives to states to increase adoptions from foster care.

Under CAPTA, for 2014 Congress provided a total of \$94 million to support three distinct grants: One was the state grants to improve child protective services. Two, community-based grants, sometimes called CBCAP, we heard a CBCAP person yesterday, and funds to HHS to support research, technical assistance, and other grants related to prevention.

Then we come down to the one program that is not administered by HHS, this is the Department of Justice, Victims of Child Abuse Act. Also, this money does not go to state child welfare agencies. It is a modest sum, a total of \$27 million in 2014, \$19 million for children's advocacy centers, \$6 million for court appointed special advocates, and \$1.5 million for the [inaudible] program.

So again, the program with the most money, including all the funds that are appropriated on what Congress refers to as a "mandatory basis" are handled in Congress by the House Ways and Means and Senate Finance Committees. CAPTA and a few related programs, by contrast, are under the jurisdiction of the House Education and the Workforce and the Senate Health Committees, and the Victims of Child Abuse Act programs originated and have been handled in the Senate and House Judiciary Committees.

Dr. Rubin : [069:00:29] Where is Title V?

Stoltzfus: [069:00:30] Title V is in the Senate Finance Committee and the House Energy and Commerce Committee.

Dr. Rubin: [069:00:09] What are the scope of those resources do, wrapping around? I mean where do they fit in this matrix?

Stoltzfus: [069:00:45] So Title V is the Maternal and Child Health Block Grant. It provides funds to state public health agencies. I am trying to remember what the funding is. I have it later in here, but it is like \$638 million, I think. Is that what you are looking for?

Dr. Rubin: [069:01:05] Mostly it is for medically complex children or...?

Stoltzfus: [069:01:11] No, it is actually supposed to serve low-income populations, as well as families that have children with special health care needs. But a big part of the focus is on ensuring good medical coverage for low-income women, either hooking them up with Medicaid or wrapping around Medicaid whenever there is an issue. And I think the public health agencies also do some primary prevention work. Title V is also now where the home visiting program is located.

Dr. Rubin: [069:01:59] Yes, so it would be nice at some point, in the same way that Emilie is doing this around child welfare, to really think about the other funding on the public health side and where the various streams kind of weave in and where the opportunities might to be to kind of intermingle the two.

Dr. Sanders: Commissioner Petit.

Petit: [069:02:15] This is called federal child welfare program spending, but what you are really talking about is federal spending that goes to child welfare in one fashion or another. And I think right now the commonly accepted number that I've seen overall in the child welfare system, CPS, foster care, subsidized adoptions, medical care, etcetera, is about \$30 billion a year spent nationally, across the country. About 45% of that is federal, 50% is state, and about 5% is individual jurisdictions. So that number is about \$30 billion. CDC had a report out a couple of years ago that said the total cost incurred by the public as a result of the suffering of child abuse and neglect on the general populace is about \$125 billion a year. So that is a CDC number and not one that an advocacy group has developed, but a federal agency.

Dr. Sanders: Commissioner Horn.

Dr. Horn: [069:03:15] A quick question. I assume these are the federal appropriated dollars, it doesn't include things like transfers, or Social Services Block Grant transfers.

Stoltzfus: [069:03:22] I'm actually going to get to that, I'm just moving along slowly.

Dr. Sanders: Commissioner Covington.

Covington: [069:03:33] I had a question about where the Social Services Block Grant money goes.

Dr. Sanders: [069:03:38] I have a slightly different question or a comment related to Commissioner Rubin's question. It seems that one of the things that would be helpful for us to think about is this issue of committee of jurisdiction and what the implications are for our work. And maybe, as you are going through, if that is something you can reference, because I think that is one of the things we'll have to consider.

Stoltzfus: [069:04:00] Yes, okay.

Female Remark: [069:04:02] I also had a question. Do all of these fall under the Administration on Children, Youth and Families?

Stoltzfus: [069:04:12] Yes, they all do, with the exception of the Victims of Child Abuse Act programs, which are in the Department of Justice, Office of Juvenile Justice and Delinquency Prevention, which by the way was also sort of a child of the

Children's Bureau, because that was also the mandate of Children's Bureau, was juvenile justice.

Okay, so I have two pies. This one is just talking about the dollars, and the next will have the SSBG and other things on it. This is just showing you dedicated child welfare funding. And when I talk to dedicated, I'm saying what is the money that we're giving to states and we're tying to requirements around child protection and child welfare for child welfare agencies. And these are those dollars. And except for that orange sliver up there, which is competitive or incentive funding and often available to entities other than state agencies, all of this funding is paid to state child welfare agencies, sometimes to territories, sometimes to tribes. And the largest amounts in blue are, dark blue is foster care, and lighter blue is adoption assistance. That goes out as reimbursement for every eligible cost incurred for an eligible child. The federal government has agreed to pay a part of that cost. The light blue sliver is the services for youth aging out of foster care. The yellow pie is money that is provided to states for services to children and families, and that money doesn't really have federal eligibility restrictions, it's up to the state to decide who needs the services, but of course the funding is limited.

So I wanted to say that actually in nearly all of these cases the states are also required to come up with their own dollars to draw this money. So this is talking about the federal pie. Usually, CAPTA being the exception, where you don't have to put matching dollars, 20% to 50% of the program cost is the state costs. So to draw down the money here we would expect the states to probably contribute about 3.9 billion of their own dollars, and as you will see in this next slide they actually spend quite a bit more.

So these are, I think, the numbers that Commissioner Petit was talking about. This is a survey that has been done, actually, for a number of years. It started with the Urban Institute, it is now Child Trends. And it shows that in state fiscal year 2010 the total child welfare expenditures by state child welfare agencies, so money out of the child welfare agency, was a little more than \$29 billion, with more than half, 54% of those dollars, supplied by the state from non-federal sources, and the remaining 46% supplied from federal dollars. So as you can see beyond the federal dedicated funding that I described, states make considerable use of other federal funding streams, and notably these include the title IV-E program known as TANF, Temporary Assistance for Needy Families, and the title XX block grant. And there is some Medicaid funding shown here, and I want to clarify this is a very limited amount of Medicaid funding. This is Medicaid money that the state child welfare agency is responsible, essentially, for providing the non-federal share. So I'm not talking here about basic health care services provided to children in foster care or any of the basic assistance that we expect of Medicaid, and that Medicaid is required to provide to eligible foster care children, these are for special services that are used for the foster care population, typical targeted case management, rehabilitative services, some Medicaid-funded therapeutic foster care. Hope is nodding, which is good, since she did this survey.

Covington: [070:03:24] Is that mental health services then, for kids under Medicaid, or not?

Stoltzfus: [070:03:29] No. I mean if the Medicaid agency is the agency that is providing, the reimbursement is probably not going to be...I mean unless there is something under one of these rehabilitative services.

Dr. Rubin : [070:03:42] Yes. So the services themselves would be funded through traditional Medicaid case managers, and what happens with those is you end up getting some duplication at the local level where you have health systems that are doing targeted case management and child welfare systems at the same time, again getting back to this issue of how well systems communicate. And so you get parallel structures. But I think the intent for this money was to recognize that child welfare had a responsibility around health care coordination and kids with the most challenging issues medically and in the behavioral health spectrum.

Stoltzfus: [070:04:18] Okay, so now I'm intending to take a little deeper dive into CAPTA, IV-B, and IV-E, and I wanted to start, first of all, by numbers about children coming to the attention of the child welfare agency.

CAPTA is sometimes described as the front door of child welfare because it is the system that requires states to receive reports of abuse and neglect, and that is how child welfare agencies learn about families in need of their services.

So this is a duplicate number, but in 2012 there were a total of 6.3 million children referenced in reports to child protective services hotlines. The hotline screens the calls and makes determinations about whether or not this meets the state's definition of abuse or neglect, whether or not the call should be referred to a different agency, maybe TANF, maybe juvenile justice, maybe the call is about a child in another jurisdiction and needs to be referred to a different jurisdiction. In any case, many reports are screened out, about 39% or 40% are screened out, and in effect a CPS response was provided for about 3.8 million children. Of those children, 1.2 million received some services after the investigation. Now that is not the number of children found to be victims in the state, that is the number of children that the agency determined needed some services or were provided some services. Most of those services were provided to children, 79% of those children received the services in their own homes, not in foster care.

686,000 children were found by the child protective services agency in their states to be victims of child abuse and neglect, and yesterday we had some important discussion about how states have different definitions of child abuse and neglect, and also very important, how they have different levels of evidence. And I think yesterday Dr. Berger mentioned Kansas has a "clear and convincing" level of evidence standard, and I want to say that they made that change on level of evidence in the mid-2000s, I think, and it made an immediate effect in their reported number of child maltreatment victims. So it really has an effect on how many children are counted. And I think one of the things that came up yesterday, and is important to keep in mind, is that the determination of being a victim is not necessarily the sort of "be all and end all" in terms of families that need services. We have a lot of families coming into contact with child welfare that may not be meeting the standard of abuse and neglect, but they might need our help.

Martin: [071:02:37] We've seen a lot of standards. So ICWA has a standard of actual abuse as opposed to reasonable efforts, Kansas has a standard of "clear and convincing" evidence, where Illinois has a standard of a "preponderance."

My question is, are there any studies out there to demonstrate that there are more fatalities if it is a preponderance, a lower standard, and there are less fatalities in child abuse where you have actual abuse is required to get a child into the system. Are there any reports, evaluations done comparing the standards that are used by different courts and tribal courts to affect or give us some indication about the fatalities?

Stoltzfus: [071:03:27] That is a great question. I don't know of any. I mean I'm thinking that since I am usually looking at national data and thinking about how poor the national fatality data is, I would want someone to have done a more careful study than that. So that is a very good question. I don't know of that.

Dr. Sanders: Commissioner Covington.

Covington: [071:03:47] I am still a little confused about the CAPTA funding and how states receive their funding. How do they decide how much a state is going to get, and is there an incentive or disincentive somewhere in this?

Stoltzfus: [071:04:02] No. So CAPTA money is not a sort of open-ended pot. The only open-ended pot is title IV-E. So CAPTA is what is called a "formula grant," and basically the formula is actually now written into law, and it didn't used to be. But it says that every state gets \$50,000, and then after that the money is distributed based on the number of children under the age of 18.

Dr. Sanders: Commissioner Rubin.

Dr. Rubin: [071:04:39] You know, one of the things I think essentially where a state has changed their evidentiary standards, "Did we see a change in their fatality rate?" And if they start substantiating much fewer children, was there potential balancing or unintended consequences if fatality rates went up? You at least would like to know that if they are changing their thresholds by which they substantiate child abuse and neglect that we are not also seeing on the back end an increase in fatalities or serious non-fatal injuries to children, right?

Stoltzfus: [072:00:14] And one of the reasons I asked the question is we know that when we change the definition of neglect at our state levels our numbers alter drastically! It's almost immediate. So if you change and broaden the definition of neglect you get more kids into foster care, right? If you shrink it or constrict it you get fewer kids. And it is an automatic response. And so I do think we should consider some effort in determining whether there is a difference.

Dr. Rubin: [072:00:44] Yeah, I talked for a long time, at least locally, in Philadelphia. I mean we've talked about there is a lot of movement in child welfare right now around the threshold by which you substantiate child abuse and neglect, moving kids out of foster care. It is not to say those are bad things! But I think some places are doing it with fidelity and other places are sort of closing their eyes and they

are praying. And I think this is why these near-fatal injury reviews or the child death reviews, when they are interdisciplinary, and they include people from across the city, including our hospitals and our public health response, you can ask, “When I make a change as a Commissioner in the way we are investigating cases do we see evidence on the back end that there are more kids showing up at the hospital?” And I don’t think that happens frequently enough. And so that is something that I think is important. I think you were kind of getting at a really thorny issue there, right?

Dr. Sanders: Commissioner Horn.

Dr. Horn: [072:01:44] This is a somewhat related question. So I am struck by the 397,000 figure at the end of the fiscal year, because I remember there used to be 500,000 to 600,000, and it kind of stayed at that number. So it is quite a drop! Is there any evidence that the drop has a corresponding increase in fatalities, or are we just getting better at maintaining kids in their home or maybe pushing kids quicker and more efficiently to adoption? I mean is there any negative or down side to that decrease in that number?

Stoltzfus: [072:02:17] Well that is a good question. The data that we have, first of all, as we know, on fatalities are not good. Yesterday the five-year trend is not up, but the meaning of that is questioned. We do have data on sort of how states report the number of children maltreated, and what we see is that maltreatment rates have actually gone down as well. They have been in decline for most of the decade. And most of that is tied to declines in physical abuse and sexual abuse. Neglect has either held its own or increased, in terms of rates of experience. And there have been questions about the reporting. You know, every time you have these data they are like, “How good are the data? Do we believe these data?” So they are the data that we have, and there was also, in fact, a national incidence survey of child abuse and neglect, NIS-4, and that was just completed, which did, in contrast to earlier surveys which showed an increase as well, also mirrored the national state administrative data in saying that there was a decline in child abuse and neglect, and particularly in physical abuse and sexual abuse. And the reason that the caseload has gone down, the foster care caseload is a function of entries and exits, it peaked in 1999, until about 2005 it was really all about states doing a better job of getting kids out to adoption, or maybe guardianship. The entry rate pretty much stayed the same, even went up. And then around 2005-2006 you see a decline in entries as well. So now the decline is driven by both maintaining that level of adoptions and decreasing the entries.

Dr. Sanders: [072:04:22] I have a couple of others to comment, but I would just note that during that time the recurrence of maltreatment rates have also declined in correlation with the reduction in the total number of kids in care. Commissioner Covington?

Covington: [072:04:39] A couple of things. I think if you really try to correlate evidentiary standards with fatalities it is going to be so hard to do. You have to really look at total fatalities in the state because of the way get counted. As soon as you lower or change your evidentiary standards different kids get identified and die from abuse and neglect anyways. So it is almost going to be a parallel shift. So I think you have to really look at your total fatalities over age.

Dr. Rubin: [073:00:06] Total fatalities, I agree.

Covington: [073:00:10] The other thought is I wonder how the trend toward differential response fits into some of these numbers dropping so much.

Stoltzfus: [073:00:18] I don't think that would affect the... okay, so differential response is a model that states use instead of always conducting an investigation of child abuse and neglect. They might actually go and if the hotline says, "This needs a response, but we don't think the child is at immediate risk," and they can go and engage the family and talk about what the family might need to keep the child safe. And the NCANDS people have worked very hard to try to make sure that the state use of differential response doesn't produce funniness in the numbers. So there are states that do, sort of by definition, if you get an alternative response as opposed to an investigation you are not a victim. But I think more states allow for a case to be switched to an abuse case, even if they get a differential response.

Dr. Sanders: Commissioner Martin.

Martin: [073:01:34] So when we were talking about whether or not it has been a good thing that we have reduced our numbers so substantially in the last decade, one of the things that I think has to figure into that is whether or not we think it is a good thing that more of our kids are being adopted and going into guardianships, and we are closing cases out that way. And I would suggest some people or some pockets in our community may not necessarily agree that is a good thing, and that we should spend more effort in trying to reunite and keep families together. That is one comment.

My question to you, or another question to you is has there been any kind of work done on... some states allow full circuit, elected judges with general jurisdictional authority to handle child abuse and neglect cases. Some jurisdictions allow Commissioners or quasi-judicial personnel. And I personally don't think there is any difference, but I can tell you that the three states that are mostly responsible for that reduction, all of them have general jurisdiction judges. So you look in New York, Los Angeles, and Chicago, all of those states have general jurisdiction judges. And some judges and some current personnel are talking about the authority that is granted to these magistrates or these judicial employees. And I am wondering has there been any work done in that area as well?

Dr. Sanders: Commissioner Petit.

Petit: [073:03:06] In response to Commissioner Martin's point about whether there has been an increase or decrease, at the Child Welfare League of America we used to keep statistics on how the states are doing in comparison to each other, using whatever their own definition was, let's say removal rates, or substantiation rates. And when you created a descending order bar chart from the state with the highest rate of removal of children from their families in the state to the lowest rate, it was a multiple of hundreds of percent, not 10% or 20%, but three-fold, four-fold, five-fold. And that was true across the whole range! So that is between states, among states. Then if you look within a state you could see that even within a state, from region to region, there were some similar differences within the state, operating on the same standards! And then when you went to a child protective services unit with, say, 9

workers and a supervisor, and you looked to see what the substantiation rate was of the cases they were investigating, there was the same sweeping difference in those kinds of things! So what it really speaks to is a lack of uniformity, a lack of standards, a lack of training that allows a lot of freelancing to go on.

With respect to the National Incidence Study that was just referred to, I haven't seen the fourth one, but in the first three NIS studies, which HHS conducts, they claim in those reports that the capture of kids who were abused was about 1/3 of all the kids that were abused and the real number was double or triple what they were actually capturing.

The other thing I would note is that Commissioner Specia here, or when I was Commissioner Petit in Maine, if we went on the air and said to the citizenry, "You need to start telling us whether you see kids who are being hurt," you could pop the numbers 10%, 20%, 30%, or 40% in a 2, or 3, or 4, or 5-month period. So I'm asserting that there is a lot of elasticity in all of this stuff, and I don't trust the numbers without a broader discussion of what they actually show.

Dr. Sanders: Commissioner Martin.

Martin: [074:00:01] And so to that point, I'm beginning to understand, and I will tell you I'm one person who came to this Commission without a detailed understanding of how flexible or fundable these numbers are, but having listened to you and speakers, and understanding how these numbers don't necessarily, and probably more than likely, do not represent adequately what we are looking for, I think we really need to sit down and make a decision; do we kind of hunt and dig until we get a better number or do we deal with "pick a number, deal with it, and then work from there." I don't know if our Commission really gives us the jurisdictional authority to sit down and find the best number or develop the best number, as much as we need to do to find a working number that we can somewhat agree on that this is the best representative, take that, and then work forward.

Petit: [074:00:51] Yeah, I don't think they are mutually exclusive, but I think we can say within a reasonable time period, "Here is what we think is the number. We think it is a range from here to there, it's not precise because we don't have the tools yet to measure it precisely, but what we are interested in is based on what we do know. How can we reduce these child deaths now?" And I think that, as I have been listening to this today and reading material, etcetera, I think we can do both of those things. I think they are very much related, and at some point we can make a case for why we intervene, and what does it roughly look like, and what are the resources that we currently have committed to them? How close are they to what the actual need is?

We just heard a presentation, and there is no discussion whatsoever as to how related it is to what the magnitude of the problem is, just a number, and it's \$30 billion. Well maybe we need \$130 billion, and we need \$40 billion, but I don't think they are mutually exclusive. I understand your point about moving towards action but I think we do have to have some kind of a rock baseline that says, "This is what our best knowledge is right now."

Dr. Sanders: Commissioner Covington.

Covington: [074:01:48] I agree that the GAO spent a year trying to come up with a number and had no luck at it, and a lot of people have been trying to come up with numbers and don't have any luck. To me, what we should be doing is moving forward to think about how we can eliminate some of the, as you called it, elasticity in those numbers so we can try to get some standardized numbers and some real numbers, at least around fatalities. That is what I am focused on.

Dr. Sanders: Commissioner Horn.

Dr. Horn: [074:02:12] So I'll join this conversation. It would be a really bad outcome, it seems to me, if our recommendation is "we need better data." So we have a certain amount of data, it is what we have, it's not awful. It's not great, but it's not awful in the sense that we know the real number of fatalities is not 100,000, we also know it is not 1. We have some magnitude that we have some sense about, and I think we do need to plow ahead and whatever the real number is, let's understand what the data is, look at it, and try to make the best recommendations we can for actual action.

Stoltzfus: [074:03:02] Okay. This next slide actually talks about CAPTA state grants, and this is \$25 million that is asking states to assure quite a number of things that they do. And I have listed assurances that must be given here. This is not a full list of assurances, states need to provide more things. But at the beginning and from the beginning states have been required to assure that they can receive and respond to reports of known or suspected child abuse and neglect. They have to provide a response that ensures the safety of the child. They have to ensure the confidentiality of the reports. They have to offer immunity for good-faith reporters, and also, from the very beginning of CAPTA, they have been required to include provisions related to cooperation of law enforcement, courts, and state human service agencies in responding to the child abuse and neglect cases.

In 1996, reauthorization provided for citizen review panels to evaluate the work of child protective services, and it also said that states had to ensure that they weren't requiring children to be reunited with their parents if those parents had committed sort of a heinous crime against another child—murder or serious bodily injury. They required health care providers, and this was a 2003 amendment, to notify the CPS when an infant is born affected by illegal substance abuse. The language was changed a little bit in the 2010 reauthorization, mentioning withdrawal symptoms due to prenatal drug exposure, and also adding Fetal Alcohol Spectrum Disorder. The 2003 amendments also required that there be provisions to refer to the IDEA Part C program for early intervention services for children who are found to be victims of abuse or neglect and are age 2 or under.

And the most recent reauthorization, 2010, stated that states have to provide for systems of technology that support the state's CPS and track child abuse and neglect reports from intake to final disposition.

Further, there has been a lot of talk about the voluntary nature of NCANDS. The 1998 required HHS to develop a system, and the 1996 law required states, to the maximum extent practicable, to report certain information, including the number of fatalities.

Dr. Rubin: [075:00:49] So again, here we have a thread. So we have this requirement to report to CPS around substance abuse and around prenatal exposure to drugs. The question is what does the back end of that look like? And I know this is an issue of friction because the question is “What is the response?”

Stoltzfus: [075:01:09] Yeah, so the law actually says that you have to develop a safe plan of care for the child. And I was just looking at the guidance on this and HHS is saying that the Children’s Bureau, the safe plan of care doesn’t necessarily have to be developed by CPS, it can be another agency. But beyond that, it is true, what is the response? But I would just say that the reason for the referral, the reason that Congress sought the referral was they wanted to ensure that there was a safe plan of care for them.

Dr. Rubin: [075:01:44] Yes, because this is a major touch point right there. We already have a risk factor there; we have prenatal substance abuse. And I think to me the challenge in part, seeing this play out at the local level, is I’m sure the local response is completely varied and it is not incentivized. What is the proper way to support families at the time that is identified?

Petit: [075:02:12] The states end up making political decisions about how much money is going to go where, based on who is asking for it. So in some jurisdictions the prevailing political view says, “Spend more money on it,” and others it’s not. And it is a crap shoot from one jurisdiction to the other on whether you get assistance, including substance abuse in the health care system.

Stoltzfus: [075:02:32] I just want to say this is one instance where Congress actually amended the IDEA to say that you should refer to early intervention services but not on this.

Dr. Sanders: Commissioner Martin.

Martin: [075:03:08] And so the point is that it is varied throughout even a city. So I have no “coke babies” in care from Northwestern Hospital, which is located on the Gold Coast, behind Saks Fifth Avenue, but I have all my coke babies from Cooke County or Stroger Hospital, which is the public aid hospital. I talk to the social workers at the hospital and at Northwestern, they say they look at the risk factors and they look at the family support and they make a determination that a DCFS hotline call is not necessary, but somehow, at Cooke County every woman who is under age, underweight coming in to deliver at 2:00 in the morning gets a toxicology. So yes, there is a cross point, but the cross point needs to have incentives so the hospital as well as the department is incentivized to make certain that we treat both instances in a similar way. I don’t want more kids in foster care, but I want all the kids who need to be in foster care in foster care. And I think that it is imperative that when we look at the fatalities, likewise our recommendations are done in such a way that we minimize the variance in how we interpret what our recommendations are, right?

Dr. Rubin: [075:04:20] Yes, I’m thinking also, what is the coordinated mental health response to that parent? You have a moment, they have a new child home. I’m not even thinking about removal, I’m thinking about this is a moment here where a child is

clearly at risk. I think if we did that risk factor analysis, in the perfect world we would probably find substance abuse, and poverty, and all risk factors for child fatality. It is still a needle in the haystack, but what is the appropriate and coordinated response with the local health jurisdiction? What should it be? And I don't think that has been well defined or incentivized.

Dr. Sanders: Commissioner Zimmerman.

Zimmerman: [075:04:57] I just want to make a comment also for many tribes, which again, are sovereign nations. They have created tribal codes where they will arrest and incarcerate a mother who is known to be using alcohol or drugs and pregnant in the hopes of getting her assessed and into treatment, but that can take weeks and months. And so some have tried to use that as some sort of management when there is not access or there is not the ability of the family to support that mother. I have some issues around civil rights, but tribes are feeling like they are stuck and are backed into this place of trying to find the best way to protect the unborn child and their future.

Dr. Sanders: Commissioner Martin.

Martin: [076:00:49] The more and more I listen to Commissioner Rubin, I'm beginning to agree with you more and more. Because when you think about it, when we talk about the reduction in the overall kids not in home placement nationwide, I agree with you that I am seeing fewer and fewer cases of serious physical abuse and sex abuse but most of my cases are negligence. It is a subjective standard at best! And a lot of it is predicated on substance abuse issues, whether it is alcohol or illegal drugs, or prescription drugs. And what happens is the reality is I can't cure a 12-year drug problem in 12 months, and so the issue is whether or not the majority of the fatalities we see are with abuse cases or neglect cases.

And then also, the standard is substantial progress towards addressing the issue that brought the case to the attention of the court. It is not that you have to cure the problem, you have to get mom in treatment, and her ability to parent while she is drugging or reducing her drug intake.

And so the issue is for older children I really do believe it is more of navigating the family as opposed to the family being perfect, and sending the child home to a perfect family. The older the child gets the less I look at risk factors and the more I look at protective factors, if you will. But the issue, I really think, if I'm understanding Commissioner Rubin, wherever we find these intersects with the Health Department I'm wondering if there is a way that we can link these at the federal level so that the Health Department as well as the Children's Bureau or the children's agency has an obligation to make assessments about the well-being of our children as they go through the system, and join in the educational system. I mean if we think about the testimony we received yesterday, and it is still troubling me that no one knew this, or at least I never heard it until yesterday, that of the 17 deaths that they experienced in this county not one of those kids had a CASA! Now from a lay person's perspective, not a researcher, I don't know if the sample was sufficient to qualify and all that, but if I take that for what it says to me off the top of my head, the more eyes and hands on my kids, the better chance they have of living through this system. So it makes more

sense if we start getting these other systems involved and making them have the same mandates or similar mandates to the well-being of my kids throughout the life of the case.

Dr. Sanders: [076:03:31] Just for the Commissioner, and Emilie you have about 15 minutes and I want to make sure you get your high points. Commissioner Petit?

Petit: [076:03:40] Let me say I agree completely with what you said, with what David has said, there is no question that there ought to be an early point of intervention and a CPS referral, and the fact of the matter is that the least threatening and the most benign system that sees everybody is the health care system. There is no question about that, although we have a situation in Texas, and I don't know if these numbers are still current, but a few years ago they had 400,000 live births in a year and 40%, 160,000, had late, little, or no prenatal care.

But can I just introduce a perspective, again reminding ourselves, this is the Commission to Eliminate Child Abuse and Neglect Fatalities, not child abuse and neglect. Because eliminating child abuse and neglect, in my mind, is much more challenging because it is a ubiquitous, pervasive problem in our culture. So the question is how can you keep returning this to fatalities knowing that in the end the only way you are going to reduce mortality is to reduce morbidity, right? But I think it is just a humongous, beyond our capable capacity, to look at how do we reduce the whole issue of child abuse and neglect.

Dr. Rubin: [076:04:38] I think we are going to have to start putting Emilie on the road with us. She is going to get about 15 minutes of her presentation in at every location, right? [laughing]

Dr. Sanders: [076:04:47] Let your bosses know that then. [laughing]

Stoltzfus: [076:04:50] Okay. Well I'm just thinking about what I should actually talk about. My next slide was about CAPTA definitions and I think we've talked about them so maybe I'll just skip.

Dr. Sanders: [077-00:10] I'd really like to go through that. I think it's a really important issue for us.

Dr. Rubin: [077-00:12] That's right. I said that jokingly but I said it in all sincerity. There's a lot of thorny issues here. I think Commissioner Petit and Commissioner Martin this is where our details are. I think the overt focus on child welfare has sort of lessened the focus on the health side. And I think that's to me as I see it play out in local practice I think that's where some of the fundamental gaps and where kids are slipping through the cracks and the fatality issue. I agree with you.

Stoltzfus: [077-00:50] Okay, so CAPTA definitions. The CAPTA definition that's in law now was actually put there in 1996 and I guess a notable part of the definition is that it does mention death, as child abuse and neglect. That means because of the CAPTA requires states to have a law that mandates reporting of known or suspected cases of child abuse and neglect, this definition then is controlling in terms of what actually someone is supposed to be reporting. Of course, it's controlling in the sense that then

states also have much more detailed definitions usually in their own code and furthermore an important part and aspect of this which also came up yesterday is that to be considered abuse and neglect for purposes of CAPTA the abuse or neglect has to have been perpetrated by a parent or a caretaker. There is not a definition in federal law of parent or caretaker. There is not a definition in the regulation and so it really is up to states. In fact, there was a definition of a person responsible for a child's welfare. That used to be the language that was in the definition before 1996. That definition was in regulation and that was contested regulation. It generally got to parent and caretaker and I think it mentioned child daycare provider, residential caregiver. The 1996 law changed again made a lot of changes to the law and my understanding from the Children's Bureau is that the regulations that are in the Code of Federal Regulations about CAPTA are pretty much moot. So they're there and they talk about confidentiality and definitions of certain things but with a few exceptions around making grants they're considered to have been superseded by congressional action. HHS has not issued any CAPTA regulations since 1990.

There is a definition of child, which is under age 18 except in cases of sexual abuse there's an age specified by state law. I wanted to point out that the definition of near fatality and serious bodily injury are actually included in the act for very specific purposes. Serious bodily injury is defined only in the context with the requirement that states must not require a child to be reunited with a parent who has committed serious bodily injury against the child or a sibling of a child. Near fatalities are defined in the context of confidentiality rules which we'll talk about next because states are required to release information.

So confidentiality rules in CAPTA. So we moved actually in CAPTA from a lot in "may." In "may," the state *may* allow you to release this information, to more *musts* and sometimes Congress has just written the *musts* on top of the *mays* so reading the laws is tricky. So overall child abuse and neglect records are required to be confidential. This is from the original CAPTA and the reason given is, "to protect the rights of the child and the child's parents regarding what is within the law." So who must have access and in what instances because it's not just a blanket release of information. A federal, state, or local government entity or agency needing the information to carry out a study under the law to protect the children from abuse and neglect.

Citizen review panels: If the information is needed to carry out their functions under CAPTA, child fatality review panels to the extent that in child fatality or near fatality cases who may have access is individuals who are the subject of a report, a grand jury or court upon finding if the information is necessary and other entities like researchers that the state determines under law that this information be used for a legitimate purpose. So the public must also be allowed access to findings or information of cases involving child fatality or near fatality.

In the 2010 reauthorization, the Senate Health Committee Report noted that public disclosure of information about a case of child abuse and neglect that resulted in a fatality or near fatality they argued ensures accountability of protective services and can drive appropriate and effective systems reform, but they added that they didn't believe that all states were following this requirement and they asked HHS to develop clear guidelines in the form of a regulation, providing information to states about how they are supposed to carry out this confidentiality or disclosure of the information.

HHS has released guidance since then around the confidentiality rules. There haven't been regulations but in that they say that, "States must develop procedures for the release of information including but not limited to the calls of and circumstances regarding fatality or near fatality, the age and gender of the child, information describing any previous reports or child abuse and neglect investigations that are pertinent to the child abuse and neglect that led to the fatality or near fatality, the results of any such investigations, and the services provided by actions of the states on behalf of the child that are pertinent to the child abuse and neglect that led to the fatality or near fatality."

Then comes the exceptions. But it says, "That states may allow exceptions to the release of information in order to ensure the safety and well-being of the child, parents, and families, or when releasing the information would jeopardize a criminal investigation and interfere with the protection of those who report child abuse and neglect or harm the child or the child's family." So you figure it out.

Petit: [078-02:40] Whose determination is that?

Dr. Rubin : [078-02:42] The child welfare system is changing now with differential and alternative response, and I think one of the things that we look at is what constitutes a report that can be shared. In most systems, it's a substantiated report that is not yet been expunged. What happens to all these differential response reports? These reports that lead to differential response. It's not to say that you want to criminalize or mark a family with these reports but there has to be a mechanism as we move to alternative and differential response that allows some of that data to remain in place so that systems as they respond to the next report they actually know about the 3 or 4 other times a family has been referred to differential response. I don't know how that is being handled in both the federal and state level.

Dr. Bevan: [078-03:33] I wanted to ask Emilie can you provide us with the guidance? Wasn't it just issued?

Stoltzfus: [078-05:00] Yeah, I think it was in 2012 this guidance was just issued. I didn't say one of the many requirements that I left out of the list of assurances was the requirement that states have a policy for prompt expungement of child abuse and neglect cases, but there's not a definition of what that means. States vary widely in the amount of time that they leave records on. But one thing that HHS has said in guidance to states is that they should consider that the requirement for a prompt expungement doesn't mean that you have to erase all of your information for purposes of child protective services. The prompt expungement they suggested is more around what would become publicly available, particularly because now we're moving to so many records checks. Criminal-based record checks or child abuse and neglect registry checks for purposes of job applications, and I think that is a concern of maybe due process or a variety of things that concern folks around access to those registries.

Dr. Sanders: [079-00:00] It looks like there's several questions and comments so this is probably the last slide that we'll be able to go through and then we'll certainly do some planning about the next meeting and continue discussion. Commissioner Covington?

Covington: [079-00:13] I was going to suggest this is such a huge topic. My recommendation is that we don't even continue discussing it but that we save. I think we can spend an entire meeting on this issue. It's huge. I mean it's all we hear about the states on a regular basis.

Dr. Sanders: [079-00:24] This is a major topic for Florida. Commissioner Petit?

Petit: [079-00:35] I agree with Teri. My perspective is less the state and more where the press comes on and to what they actually have access to in terms of educating the public. The guidelines have been issued by the Children's Bureau, do they have a force of law?

Stoltzfus: [079-00:43] No, so that's the thing. There hasn't been, like I said, the regulations that are on the books about CAPTA are from 1990 and are considered in communication with them offline to be superseded by federal law. So in most cases not having meaning. This guidance is part of the Child Welfare Policy Manual which is an online thing, which is instructed to states but it does not have the same power as a process. The federal regulation has to follow the policy of Administrative Procedures Act, which means it has the effect of law.

Petit: [079-01:34] So they are directed and encouraged to do it, but in fact they're not. And there's only a handful of states. I get a call literally every week from some journalist someplace that says, "How do I get information on this basic case? Did they see the kid? Did they go out? Who made the report?" Even when a child is dead, even after the parents have been convicted, there's still jurisdictions that will not release any information. In some instances they won't release information to state lawmakers who sit on the judiciary committees that make the laws that govern these matters.

Dr. Rubin: [079-02:06] Working with the data they don't even know. They have expunged the data from their data systems. They don't know how many times that phone calls came in on the kid. So that's what I'm talking about. How do you handle these contacts that don't rise to a substantiated report from the performance management aspect.

Dr. Sanders: Commissioner Horn?

Dr. Horn: [079-02:25] We should dedicate a lot of time on this issue because this is not as easy as it sounds. I think that one of the things we have to do is know what the facts are. What's in the statute? What's in regulation? What's in guidance? What's about to come out is a confidentiality toolkit from ACF which isn't even guidance. It's just like a toolkit. So I think we have to methodically go through those various levels of what is required. What is permissible and so forth and then wrestle with the very difficult issues. The difficulty with this is hindsight it is always 20/20. Somebody has seen that kid who winds up dead. There are a lot of kids who don't wind up dead. Who have false reports against them that don't get expunged and then what happens is they go to teach in their church's nursery, bible study and it comes back this kid's in the Child Abuse Registry. He's like, "What?!" So these are very difficult issues that I think we have to wrestle with. In particular, given big data that's not even in official systems. Apparently the NSA has everything from any email and phone call I ever made and text. So I think these are really timely issues that we have to wrestle with.

Dr. Rubin: [079-04:18] It's just a follow up. I'm going to give you a real concrete youth case. We're going to hear from folks around predictive analytics. There's probably a threshold for the number of times a phone call is made. At a certain point at least on the investigation side that you don't keep tracking this to an alternative response because you don't know that there's been five phone calls before that have gone on the same mechanism. We've all been on child death reviews where they just made that mistake and no one's ever gone out to the home to really investigate. I think from a predictive analytics this is a critical issue. There's a difference between labeling a family in terms of preventing employment and all the other things versus allowing the system to conduct a performance management to ensure that they're efficiently moving kids into investigations who need to be investigated because there's just been too many contacts.

Dr. Sanders: [080-00:13] If this were easy it would be easy.

Dr. Rubin: [080-00:14] Yeah, this is tough.

Petit: [080-00:15] It's not rocket science, it's hotter.

Dr. Sanders: [080-00:16] Thank you Emilie. The idea was to expose us to these issues and I think she did a remarkable job. We will dedicate enough time in the Florida meeting for this topic. I think it's linked in our website that saw the story in Florida today about the records that were not reported to the media and the firestorm that that's created. We are making a transition to a panel that will be presenting on medical issues, medical experts Dr. James Lukefahr who is the Director of Children's Hospital of San Antonio, Center for Miracles. Dr. Chris Greeley, who's the Professor of Pediatrics at the Center for Clinical Research and Evidence-Based Medicine, University of Texas Health Services Center, and Dr. Rebecca Girardet who is the Director of the University of Texas Medical School, Division of Child Protection Pediatrics. Each of them will have 15 minutes to present, then we'll have about 15 minutes for questions from the Commissioners. So thank you very much for taking the time and coming to help educate us. Dr. Lukefahr?

Dr. James Lukefahr: [080-02:24] Thank you. It's really an honor to be here. Thank you for having us and I'm from here in San Antonio and I'm the Medical Director of our child abuse and neglect examination facility, which is at the Children's Hospital in San Antonio on the other side of the freeway. So I'm primarily a clinician. What I would like to address today is basically from my point of view is, who decides if the child death is related to maltreatment and how is that determined varies by entity and there are three primary entities that make those kinds of determinations and the first is the criminal justice system. The police, prosecutors, and courts I would say that system is driven to a very large extent by the medical examiner's determination of manner of death.

There are only five manners of death. It's a fairly restricted determination and the purpose of that determination really is primarily whether or not a crime was committed in the context of that particular child's death. Child protective services here in Texas makes a determination of whether or not a child death is abuse or neglect related, and they follow terminology that is spelled out in the Texas Family

Code as far as making that determination. To me that's an important distinction because the same child's death could be ruled accidental by the medical examiner. Let's say in the case of a drowning or undetermined in the case of a sleep-related death but could still be determined to be abuse or neglect-related by child protective services if for instance substance abuse was identified in the parents at the time of the child death or other factors like that.

The third entity would be the Child Fatality Review Team, which in my experience largely reviews cases after investigations are over with so they don't necessarily affect ongoing investigations. They are really sort of after-the-fact reviewers for purposes of aggregating data, identifying prevention opportunities and things of that nature. They are also driven to a very large extent by the medical examiner's determination as well. So I think I have some examples of the discrepancies between those groups here coming up in the next slide.

This is an overview of some of the maltreatment death data for here in Texas. The Department of Family and Protective Services which is the oversight agency for CPS issues a pretty extensive annual data book. As mentioned, one of the items in the data book is the abuse and neglect-related child fatalities. The good news is that there's been a very strong downward trend over about the past five years here in Texas from a peak of 280 deaths as you can see in 2009. Now trying to compare that information to the Child Fatality Review Teams annual report is difficult and a big reason of course is the classification of deaths by manner of death. So as you can see, the 2011 data, which is the most recent that's publicly available, there were 43 homicides due to abuse in Texas and there were 65 drownings involving neglect and at least in the publicly available data that's really about the most that is available in terms of how many deaths are specifically due to abuse or neglect.

There's some other items that are examined in the report of course but not specifically linked to neglect, and a big one is the sleep-related infant death cases in which babies or small children are found in an unsafe sleep environment, frequently asphyxiated or whatever, but there's no direct link in the public annual report to how many of those really the review team regarded as being due to abuse or neglect.

The two data sets really are just not comparable and there are other issues that interfere with comparing them as well. For instance, the DFPS works on fiscal year and the child fatality review team works on a calendar year, which adds to the mismatch.

I would like to point out some developments here in Texas on the medical front that I think are very important. And the first one, on a national level, the medical subspecialty of board-certified child abuse pediatrics was recognized in 2009. Also in the 2000s there was a national effort to establish Child Abuse Centers of Excellence at certain academic facilities throughout the country. This actually did not come to pass but the goals and objectives that were set forth in that effort were adopted by the nation's children's hospitals, and in turn the Texas legislature provided funding for Centers of Excellence here in Texas and that happened in two waves.

In 2005, the Forensic Assessment Center Network was funded by the Department of Family and Protective Services. So all the CPS investigators now have access to consultations with child abuse pediatricians. My colleague Dr. Girardet is actually the

lead physician in that program and I think she's going to tell you more about this. In 2009, the legislature funded a program called Med Cares, which is a network attached to children's hospitals and to academic medical centers to fund facilities that provide direct medical care for victims as well as education research and outreach. So in summary, we here in Texas do not have a single unitary database that we can draw on regarding Texas maltreatment fatalities. We have two databases that vary in terms of what is available publicly but is different and really can't be directly compared. As a clinician, I would certainly like to see one or both of those databases be enhanced in ways that might improve our understanding and help us identify more prevention opportunities.

The last point I would like to emphasize is that we do have a very positive development here in Texas, and that is in my opinion an unusual broad access on the part of the investigators to child abuse pediatrics expertise. So thank you very much.

Dr. Sanders: [082-01:05] Thank you very much. Dr. Greeley?

Dr. Chris Greeley: [082-01:06] Chairman Sanders and honorable Commissioners I appreciate the opportunity to give you some of my reflections. I am a pediatric clinician and a child abuse reflection and prevention researcher. I do most of my work in child abuse research and I've been asked to spend 10 minutes giving some of my reflections on the surveillance work that we're doing in Houston regarding child abuse occurrence and the materials I've provided in your packet are extra data that are not included in these slides because of the time constraints.

I'm going to talk today briefly about the Texas surveillance, the child abuse fatality data. I'm familiar with Dr. Berger and Dr. Gulino's high level of scholarship, so I'm not going to go into data details and how the data were obtained but just give you some of the information to reflect on the theme of practices in Texas. To show you how some of the stuff that has been spoken about is operationalized here in Texas. I'm going to talk a little about how we in Houston are doing some surveillance for child abuse using GIS mapping and then mapping that to community-level variables to ideally target prevention strategies toward high-risk areas that have lots of children at risk.

This is the slide provided by Susan Rodriguez, who was the state lead for the Child Fatality Review. It gives the state's experience over the past few years with non-natural causes of death and it shows the decrease of the accident and then the variability within the child homicide, which is that purple color in the middle. There was concern that child homicide or child abuse is going down versus going up and there was discussion earlier about NIS versus NCANDS and is neglect staying the same and physical abuse going down, and I understand yesterday you heard about Dr. Leviathan's work demonstrating hospitalizations perhaps have not been going down and our data from Texas has confirmed that our numbers of hospitalizations for child maltreatment have actually not gone down it's gone up. That's approximately a 5 percent increase over the past 7 years, which is a little higher than our data show would be consistent with just population growth. So we anticipate that the numbers of kids when this would be converted to rates likely has gone up as well as the rates have actually gone up as well. Slightly but we believe significantly. These data will be submitted for publication in the summer.

So the question of what we will use for surveillance is because of the fuzziness or potentially head of NCANDS or CPS or DFPS fatality review our group has focused mostly on hospitalizations because that's something that we understand, that's something that we can translate into a language that we as physicians understand. And it's comparable to other states and national estimates of the same. So again just to highlight some of the Texas data again part of what we were asked was to present some of the Texas data. We do see that Texas fatality again these are data from the Child Fatality Review demonstrates again infancy is the highest risk period. We can see it's consistent with other national estimates about 40% or so in the first year of life with fatalities and about 80% in the first four years of life.

Again Texas also consistently has a pretty even ratio distribution. Likely after we work through the data a little bit more there's a slight overrepresentation of minorities, African Americans in Texas, but that is something that we're currently working through now.

So what are we interested in? We are actually interested in how do we surveil better so that we can target resources to high-risk areas and these are data that we're going to be submitting shortly where we used hospitalization rates so state discharge data and are able to map it to first of all counties and we can then see just looking at numbers are there specific areas of counties and you can see Harris County and Bexar County which is where we are, are the two highest with the top darker sections being Dallas. So the three hot areas for just pure numbers are San Antonio, Dallas, and Houston. If we adjust it for rate we can then look at that there are certain areas even though there are fewer kids the rates are much higher and so what we would call central Texas or the Valley, sort of where we are in San Antonio in the south have a higher-than-the-population-would-have-predicted rate and also north toward Austin. So the darker areas represent areas that there are more kids given the population.

So Houston, although there's the highest number, actually the rate is a little lower than compared to other parts of the state. So we are able to start looking at are there rate-specific areas that we'd be particularly interested in. We can then use these data to look at Harris County, which is where we live. And this is a map of Harris County showing similar data looking at which ZIP codes within our county actually account for the numbers of kids. So we are able to then contextualize where these kids are coming from recognizing where in the county they are. We can then adjust it for the rate as well and we can see the southern part of the city actually has the higher areas and that is a known area where there is a high level of poverty and unemployment and other high-risk variables. So we can use hospital data, discharge data, to use surveillance that we can then track over time we feel that the hospitalization currently with ICD-9s and eventually moving as you're familiar through ICD-10s, we feel that that is likely a fairly understandable and stable metric by which we can have a conversation about surveillance and identification of kids. At least at risk. It doesn't capture as you can imagine the fatalities, because many of those aren't seen in the hospital.

I wanted to also show that one of the things we are able to do because we can use the hospital discharge data is that we have two excellent children's hospitals in Houston and we can use their data to confirm that our hospitalization statewide data matches what they're actually seeing. So this is from the Children's Memorial Hermann Hospital

provided by Dr. Cox and then the Texas Children's Hospital, both about a half a mile from each other having similar experiences and some of the maps that were included were mapping their actual trauma registry data to Houston and we confirm that what the state's hospital discharge data are demonstrating we are able to see in our local communities.

But we're really interested in a much more granular approach and to the higher risk kids. This is ZIP codes in Texas on abusive head trauma. So what we think is the highest risk for fatalities, what we think is the greatest risk, and this is all kids under five, and then we can switch it which doesn't change very much to all kids under one. So this is where the kids under one that are being hospitalized for abusive head trauma are coming from. We can then do that in Houston as well. So we are able to look at where in Houston are these highest risk kids. Kids with abusive head trauma coming from in our own communities. This is the kids under one and we can see the southern part and out toward the west are areas that have particularly high numbers of kids. So what we then are doing are able to target our prevention efforts. So all of you are familiar with some of the metrics or the paradigms of prevention. We are not going to go into that, but what we've taken is what would be either the public health or population-level approach where we want to look at the larger picture of prevention efforts not down to the individual. This reflects our embracing of the Institute of Medicine promotion that the neighborhood is the level of health and so that a neighborhood is more important to child health than the actual child or the family dynamics. We feel that identifying neighborhoods that are at risk are of greater importance to a child's outcome than identifying specific children or even families that are at risk.

And so, we use the population-level paradigm of looking at a larger population using a multidisciplinary approach where we have community groups, schools of public health, medical schools, and children's hospitals working together to direct specific targeted areas and specific strategies geared toward prevention.

So again, if the child fatality review process gives us what Texas demonstrates and these are Texas fatalities and it demonstrates what the risk variables are, how do we match those risk variables to where we know the kids are is our question. So we are able to do that. And I'm going to show you something that we've submitted for publication that deals with child sexual abuse but the same process is currently being undertaken with abusive head trauma. So we are able to map and then population adjust children seeking care for child sexual abuse in Houston. So we know their ZIP codes. We know where they live and we know what they're coming for and what their outcomes are. And then what we're able to use is using the American Community Survey ZIP code level of demographics and we're able to match what are the characteristics of that ZIP code as compared to the rest of Houston, as compared to the rest of the country, and we can look at community-level characteristics and map them to where kids with child abuse or in this instance child sexual abuse are coming from. Again we're doing this work with abusive head trauma. The material wasn't of high enough quality to present to this group. But I wanted to give you as an example.

We then can predict where the risk variables for that are per the community. So what this means is for areas in which we have larger families a ZIP code whose average family size is larger than the average family, children from that community seek care

for sexual abuse less commonly. So we know that perhaps in Texas in our region that may be either a protective factor or something that we should pay attention to. Likewise, we know that ZIP codes that have a higher rate of poverty and people who are unemployed, children who live in that ZIP code in Houston seek care for sexual abuse have a twice as high risk as those who live in communities that don't look like that. So we're able to then target our prevention strategies. Be they home visitation, parenting support strategies, if we're going to look at maternal mental health, postpartum depression, or if we're going to start looking at other community factors such as intimate partner violence we can use community and ZIP code-level data to map those to where we know the kids are coming from. The goal being then to pilot strategies in those areas to test their effectiveness. So one of our reasons for success has been that we have a very strong collaboration between two universities and two children's hospitals and community groups. So my take-home messages are collaborations between the state community groups and academia, and I'd also add in philanthropy as well. The sources of much of the community-based prevention resources in many communities come from philanthropy. That collaboration is crucial that we can use surveillance methods not just with the data that we have but we can use it in a creative way in which we can identify creative ways that are useful in targeting our resources that we can use a neighborhood-level approach. And not just whole cities and whole states but we can really target it to what the risk variables are in that particular neighborhood. And then we would be able to pilot our strategies in our local communities, recognizing that we can then sense more rapidly change given that those are the sources of data are the hospitals that are taking care of those kids right there. And with that I appreciate your time and energies.

Dr. Sanders: [084-04:20] Thank you very much. Dr. Girardet?

Dr. Rebecca Girardet: [084-04:22] Thank you for your time. I'm going to tell you my presentation is just a little bit different. I'm going to tell you about a project that some of us are working on. I'm Rebecca Girardet, I'm at the University of Texas in Houston and I run our Child Protection Division there. The other people you see listed on the slide are folks who are working on this project with me. Dr. Lahoud and our project nurse coordinator Kelley Bolton and Dr. Lukefahr who is here in front of you and then Patty Paterson runs the Child Protection Team in Lubbock at Texas Tech University.

The impetus for this project was curiosity and worry that we've had in Region 6, which is Houston and the surrounding counties, about our particularly high death rate. So this just shows you the trend over the last several years. The red line is the proportion of Texas children who live in our region, which has been approximately stable around 25%. And then the blue line is our proportion of child maltreatment deaths. We had a big spike in 2009; maybe that was related to hurricane Ike, 'cause we know sometimes that you have more child maltreatment and child maltreatment deaths following major disasters. Hurricane Ike was in 2008. We got better in 2011, but now we've really spiked again. So the question is why? Maybe it's a counting thing. I've talked to the State Child Fatality folks; they don't seem to think that there is this much variation in the way cases are counted. So maybe there is something real that is going on in the region.

So that took us to looking at statewide data. Generally on cases that are confirmed and as Jim told you one of the wonderful things that the Department of Family and Protective Services does in Texas is they publish a beautiful data book that is very easy to pull up on the Internet and it has well-organized data. And so we looked at the data on confirmed cases of child physical abuse, physical neglect, and medical neglect because those are the things that we can most directly impact as medical providers. We compared those across the state so the blue lines are the physical abuse. The red are the physical neglect and medical neglect cases. Proportional to the allegations in those regions. And I just showed you 2012 but the graph for 2010, 2011, and 2013, they all have the same pattern. Where you get this big valley in the numbers of confirmed cases in Regions 4-8. So there is something going on in those regions where fewer cases are confirmed as abuse and neglect compared to the panhandle and some of the other regions.

So our question is why? So first of all we have to ask, "What does it mean to have a case that is not confirmed?" We've looked at other things like, do the caseworkers' caseloads vary in these different regions? Not really. The department does a wonderful job of trying to keep that even across the state. We looked at caseworker turnovers, that doesn't seem to vary very much. Certainly not enough to explain the variation. And as far as we can tell in our statewide network, we are seeing similar numbers of types of cases in the different regions. At least as far as can tell. So it's not all the head trauma is in Houston for instance. There do seem to be fewer alleged cases proportional to child population in some of these regions, but you would almost expect a converse if that were an explanation.

So why are cases unconfirmed? So cases that are not confirmed it could be that they were ruled out. So maybe we're actually ruling out more cases in some regions, more than others. Cases are not considered unconfirmed if they're just not able to complete the cases. The category that we are really interested in is the "unable to determine." And we suspect that maybe there are more cases that are ruled unable to determine in some of those regions and then our worry is so those children are returned back home and repeatedly abused and neglected and then that contributes to our higher death rate in some of these regions.

So to start our project we did a focus group in Region 6 and we sat down with caseworkers and asked them why they think sometimes they are not able to confirm cases of abuse or neglect. Many of the factors that came up have to do with medical services. They're not able to get the records easily. They get the records but they don't know what they mean. They aren't able to get physicians to give them a straight answer much less put something down on paper about their impression about abuse or neglect. Or the physicians won't come to court. Or the caseworkers just don't understand the medical facts very readily.

So our research design is to partner with the FPS and first of all tease out the ruled-out cases from the unable to determine so that we're clear about the numbers that we're dealing with. Then in four of the regions of the state: so Region 1, which is Lubbock, the panhandle where they apply confirmation rates. Region 6, which is Houston. Region 8, which is here in San Antonio and we have relatively low confirmation rates, and then Midland which is Midland/Odessa, they have relatively high confirmation rates. There's no children's hospital there. That region of the state

is served by San Antonio. They're the region that our network assigns for cases. We are hoping to survey the CPS workers in these different regions and our survey is actually going through a process of being finally approved at the FPS. To survey the workers about their understanding of the availability of local medical expertise. Their understanding of when it's appropriate to ask for a medical expert to help them with a case. Some of you in this room are probably familiar with the Sunset Commission, which is assigned every year in Texas to evaluate different state agencies, and one of the agencies that they evaluated this year was the FPS and one of the things that their report stated was that our state network is a nice tool but were underutilized, which is one of the things that we suspect is going on. So we're hoping through this project is to help the FPS figure out how to utilize us better.

So these are some of the sample survey questions. Basically they are asking the caseworkers how confident they are in determining when a child has been abused or neglected. How confident they are in knowing when they should ask for medical expertise. Basic questions like if you are having a family team meeting concerning a child who has multiple medical needs, would you invite a child abuse pediatrician to come and participate in that meeting? If they have had interactions with physicians in their community or with their local child abuse pediatricians has that interaction been positive for them. We want to know the dumb things. When you call is the person that answers the phone nice to you. How long does it take you to get a child into a child abuse clinic for an exam? Maybe there's some things that we need to do in our end to improve the process.

So this is just the basic model. It's just a basic quality improvement model: plan, do, study, act. So we survey. We analyze the survey data. We come up with local interventions in each region. We implement it and then we see how well it works and then we repeat the cycle again. So we're thinking of doing this in four six-month cycles. So over a period of two years.

Jim mentioned our statewide network. This is just a screen shot of the web system that we have. So all children's protective services workers across the state and child care licensing workers have access to this system. So obviously if they are located in our local cities they can just call us and schedule a child for an appointment. Sometimes we're the ones calling them saying we have a child in our hospital and we're reporting to you 'cause we think they've been abused or neglected. Texas is vast and caseworkers out in the rural counties can submit cases into the web system. They can upload documents. They can upload photographs. They will send us the CT scans and x-rays and a child abuse pediatrician will review the cases for them and produce an affidavit. They can also call us 24/7. We have a 1-800 number and they can call us if they have questions.

So this is how we've divided up the state. So UT Southwestern in Dallas handles the purple regions in the north. UT Galveston is the green. UT San Antonio handles all the vast blue region and UT Southwestern Dell Children's Hospital is in the Austin area. UT Houston we took obviously Houston and the surrounding areas and then the Valley and then we got El Paso because nobody else wanted to go out that far. That's what our network looks like. That is it. Thank you.

Covington: [087-00:44] Do you use telemedicine for that or is it mostly phone calls, emails?

Dr. Girardet: [087-00:46] You know, it's interesting. So when the network was initially established the FPS set aside a large chunk of money for telemedicine. UT Houston, UT Galveston, and Texas Tech all have extensive experience with telemedicine. It sounds great until you get down to actually using it. For instance, UT Houston for years had a van that went down to the Valley and went around to all the little Hispanic communities and local schools and it worked great until the van broke down. And then how do you get somebody down there to fix this extraordinary expensive equipment on the van. It's a lot of money for what you get for it. So we found that it's better, talk to them on the phone, have them send us the records and to do it that way.

Dr. Sanders: [087-01:46] Commissioner Petit?

Petit: [087-01:47] That was all very helpful. I have a clarification: I'd like to ask Dr. Lukefahr about a number you presented and just the three of you just ask respond to one question. I think you said there was 184 deaths on average over the last 5 years? What was that 184 number?

Dr. Lukefahr: [087-01:49] Are you referring to the downward trend from '09?

Petit: [087-01:51] Yeah, the deaths per year.

Dr. Lukefahr: [087-01:53] Deaths per year. Yes, sir.

Petit: [087-01:55] I saw that 2009 to 2012 there was an average of 237 a year, it never went below 212. Then it dropped to 156 and I'm just wondering if that's right? You show a number of 184, it was in the beginning. I guess the question will be from the perspective of you all as researchers, and I know the department is very interested in the answer to this as well. We are interested. How could the numbers drop so dramatically in a one-year time? Is it an outlying situation? Is it something that you can trace back to cause and effect relationship but how do you explain such a precipitous drop when it's been just a steady number of 200 plus deaths a year for a decade before that.

Dr. Lukefahr: [087-03:20] I'm going to pass that question on to my colleagues. Chris?

Dr. Greeley: [087-03:22] Do I want to take it? The average of 184 is the total that were non-natural. This is data that was provided to me by the CFTR, the Child Fatality Review Commission.

Petit: [087-3:44] One of the charts we have, the numbers I am looking at are four years worth: 280, 227, 231, 212, and then it drops to 156.

Covington: We learned that yesterday, as well.

Dr. Lukefahr: [087-03:55] Those are the DFPS numbers. So one point that I would like to make is that it illustrates the fact that these are two different databases that unfortunately don't compare very easily.

Petit: [087-04:07] Okay, so back to the question either way you look at it, whether it's one system or the other, it shows a precipitous drop. What's the explanation to that?

Dr. Lukefahr: [087-4:09] Back to Chris.

Dr. Greeley: [087-04:11] So my interpretation is there is no clear explanation for that. From my perspective those data sets have a lot of fuzziness to them in which it allows for a lot of variability that could be not explained by the reality that they are trying to express. And so those two data sets are the data that I'm less comfortable giving specific numbers saying it is 184 because I'm not sure how much has gone into that to reach that specific conclusion, which is why from my perspective hospitalization data and discharge, while there are lots of problems with that, appears to be much more stable. We don't see that for the fizz data set which looks at pediatric hospitalization. We don't look for the kid data set, we don't see that for Texas hospitalization. We don't see that much variability so to me that is a much more accurate, more precise estimate of the disease. Now the problem is that many fatalities don't get captured in that. So if you're going to ask, what's the fatality number? That becomes a challenge because the data as it's been described all morning is fairly fuzzy. So I don't have a good explanation. My interpretation internally is that that is a clerical effort.

Petit: [088-00:43] There were car seats one year and there were car seats the next. Not the next year. And we can say, "Gee before there were car seats for 100 babies that were killed, now there are car seats there's 50 babies that are killed." Can we trace something in these numbers back to some action that either the health people or CPS or law enforcement or anything else?

Dr. Girardet (?): [088-01:01] It could be a change in definition. It could be clerical.

Dr. Greeley: [088-01:08] So my interpretation is having been in Texas during that interval. I know of no laws and being a parent I know of no laws that have affected parents to the degree that would explain that dramatic decrease.

Dr. Rubin: [088-04:15] Commissioner Petit, you're right where we need to be because we haven't asked that for 156. Actually in the last couple of days. When you look at the 156 if you were doing a run chart that's statistically significant. It's not just child abuse injuries. Accidental injuries are down. Unless suddenly they're just underreporting the number of fatalities that come through the coroner's offices, something changed in 2010. Something changed in 2010 and it wasn't just for child abuse injuries. Now when you look at that you say, well is it just statistical variation? Unlikely because the trend has been consistent over several years and it is in the downward. And the undetermined category has not gone up substantially enough to explain the way trends are going. When I look at a slide like that I say, "In reference to your heat maps, heat maps, over time are there certain areas in the state that are differentially explaining that decline because that tells you is there something going

on in Houston and is it about this population of response.” The other things I think about, is there a workforce threshold? We have an amazing CAC system we heard about here in the state. Then we hear about the expansion of child abuse pediatrics and I do think it’s worthy to have you guys educate the Commission on the funding challenges around child abuse pediatrics in general. I think Dr. Girardet shows how elegant cross-system collaboration can be on a quality improvement project and how the expertise can actually come across there. The data on the hospitalizations. Are we just keeping kids alive? That we’ve done a good enough job as a group of recognizing abuse head trauma, because I can add 40 or 50 cases based on the data that you showed me. That had they died these numbers would have been different. We’re now moving from death to morbidity in this state, because of the ability to get kids into hospitals with very talented physicians. Is it the economy? Is it population health strategies in local areas? I think starting with heat maps could tell you if this is across the entire state or does it differentiate in certain areas. I would like you to comment on how you might approach beginning to understand not just saying, because it’s hard for me to see as clerical, something changed in the state of Texas.

Dr. Girardet: [088-04:18] I think you may have hit on it because we certainly had over this period of time expansion of children’s hospitals’ trauma centers as well. So we may be doing a better job of getting some of these children into pediatric intensive care units faster and getting better care. That would make a lot of sense to me. We used to have one pediatric trauma center in Houston and now we have two since 2009. That may very well explain part of it. Because if you look at overall rates of child abuse and neglect in Texas there’s been a little bit of a decline to mirror the national but certainly not this drop that we see in the child maltreatment deaths, and I don’t think we’ve gotten that much better at prevention unfortunately.

Dr. Rubin: [089-00:07] Yeah, because the accidents which is just your trauma center hypothesis might be true because all injuries, all cause injuries deaths are down in children.

Dr. Girardet: [089-00:14] Yeah, I think you’re right.

Dr. Sanders: [089-00:15] I want to get a couple of more comments and then we have three more Commissioners who have comments and then we have to close up. Dr. Girardet or Dr. Lukefahr, any comment in response to Dave Rubin’s question?

Dr. Rubin: [089-0:48] I just wanted to point out that the downward trend also was obviously reflected on the DFPS data as well, which kind of adds to the idea that this is really a robust occurrence and not a statistical aberration.

Petit: [089-0:58] I would like to believe it but until researchers can say here’s what it traces back to, it’s speculation and hypothesis and it would be difficult to translate into actionable items.

Rodriguez: [089-01:00] I just had a question. I want to understand more about the child abuse pediatrics and so are they primarily in sort of a technical assistance role to the primary care physician and to the child welfare department, or do they actually take on care of a child for a set time, and if so how does that care coordinate? I’ve never heard of it before, so I just want to understand it better about what the role is.

Dr. Girardet: [089-01:02] I think it's probably a little bit different in each community, but in San Antonio they have a large child protection clinic, The Center for Miracles. We have a large clinic at UT Houston. The other Texas children's hospital in Houston also has a clinic. Some child abuse clinics will follow the children only right around the abuse or neglect event. Others will actually see foster children. Our clinic takes a broad approach so we have foster care kids, adopted kids, so we'll become their medical home for as long as they need us. We also have a lot of kids and families who are thought to be at risk, so CPS may or may not be involved yet and we have psychology and psychiatry who helps us work with those families. I know you do that in San Antonio, too, to try and hopefully keep them out of the gunsights of authorities and get them back on a healthy track. But it all comes down to funding unfortunately because so many of these families are either Medicaid funded or have no funding and so our ability to work with these families is hugely dependent on the state funds that we receive. If we didn't have the state funds, we'd have to close our doors.

Rodriguez: [089-02:51] And for the at-risk families who are not already system-involved, how do they make their way to you?

Dr. Girardet: [089-03:00] The ones that we see are primarily referred by the hospital. So children who are hospitalized for an injury that shouldn't have occurred or medical neglect that repeats itself or lots of failure to thrive babies where it's just because the family can't get it together. There's nothing really wrong with the child but the child is just not being fed.

Rodriguez: [089-03:22] And do you find in most of those cases that there was a primary care physician already involved with the child?

Dr. Girardet: [089-03:28] Not involved enough because the family is just not going.

Dr. Lukefahr: [089-03:40] The function of the child abuse pediatricians does vary a lot. There are a lot of places where the focus is either on sexual abuse examinations or physical abuse examinations. I would say in Texas most of the centers really do both. See kids for both of those plus also see children in the hospital as well.

Dr. Sanders: Commissioner Horn?

Dr. Horn: [089-04:05] Two quick questions. First, for Dr. Girardet, confused by your relative [inaudible] chart. It shows a two-fold increase in girls seeking care for sexual abuse concern where you have a combination of higher employment, and it's hard for me to read. But if you look at just higher percent family below poverty line it seems to be a protective factor. So what's the explanation for that?

Dr. Lukefahr: [089-04:42] So the explanation is there is some interaction on other variables as well that have altered the impact of that one variable. So it's a complicated algorithm that we have used to adjust for clustering, so certain areas it affects differently. So the overall we're trying to relate but certain areas the effects are different by an interaction that has to do with one of the later slides.

Dr. Horn: [090-00:16] Do you have any logic for that?

Dr. Lukefahr: [090-00:17] No we don't.

Dr. Horn: [090-00:18] Doesn't seem in tune.

Dr. Lukefahr: [090-00:19] Our interpretation was much like some of the prior data on community predictors for use. It's a complicated relationship. It's not just unemployment. It's not just underemployment. It's not just housing and that each location is a little different. There was a paper by Drake that was two years ago that showed in California it's different in Michigan and that unemployment plays a different role in those locations. So our exploration of the data are that even at a local level there is a lot of variability and interactions.

Dr. Horn: [090-00:55] We have so many pediatricians here, I'm going to ask this question. So am I to understand that SIDS is no longer a syndrome that people believe?

Dr. Lukefahr: [090-00:59] I'm not sure what other people believe in. SIDS is a real defined entity. And part of its definition is after a thorough evaluation no particular underlying cause has been identified. And people will argue that that it leaves a big void that could be explained and it has been explained historically for things we don't know yet. And so historically was inborn errors of metabolism or heart diseases that we would have said, "I don't know," but if you actually had the data you could have found that small percentage. So over the past 5 to 10 years there has been a switch from SIDS to sudden unexpected death in infancy. I suspect that Dr. Gulino has mentioned something about this. There is a debate as to how far you can go to call something SIDS if they were in the bed with the parent. And that becomes a distinction without much difference from my perspective as a pediatrician.

Dr. Rubin: [090-02:19] I think it is an illustration of how to some extent medical examiners' determinations are influencing these numbers. At least in my experience, medical examiners are less and less willing to call something SIDS and so they're driving the SIDS numbers down by virtue of their change in willingness to use that term.

Dr. Sanders: Commissioner Covington?

Covington: [090-02:54] I was going to remark on these decreasing numbers of the accidentals. That's a trend we are seeing nationally everywhere. Child death rates are going down all across the country. It really relates to hidden stories in here in terms of motor vehicle crashes, death to motor vehicle crashes are dropping everywhere due to graduated licensing and safer cars, the trauma centers are the whole increase in keeping kids alive longer. So accidents are dropping pretty much across the country. I am so intrigued in the conversation we had yesterday with Commissioner Specia who assured us that the number that you look hard to see if that was a true number if you are counting the same and you thought you were from when it was in the 200s to the 157 or whatever. I hope next year whenever you get your next number that it's dropping again, but to me that's the secret. What's going on with that number and why is it dropping? If we had the answer we'd have our work done for us. It's fabulous that the numbers are dropping. And you hope it's a real drop.

Dr. Sanders: [090-04:06] I actually had a question related to that. A question and a comment. The question is to Dr. Greely. You had identified abusive head trauma and noted the increase in abusive head trauma, and at the same time this chart shows the reduction in both child abuse homicide and homicides. And so I was wondering, does abusive head trauma correlate with physical abuse? Does it correlate with homicide? Is it separate? Can you say a little bit about that because it does seem that these numbers going down would be consistent with the reduction in the numbers that Judge Specia talked about.

Dr. Greely: [090-04:46] Certainly. The next slide is for all child abuse hospitalizations. So buried within that is the subset of abusive head trauma so the state has demonstrated a slight increase of all child abuse hospitalizations and the abusive head trauma hospitalizations themselves has remained stable. That likely represents a decrease, given the population has increased during that same interval. So likely the percentage of kids has gone down because the number has stayed the same. That's purely again from the hospitalization perspective and those are kids who are admitted to the hospital, could have died but could have survived and so our data would suggest that it has remained about the same which is likely a slight decrease in rate.

Dr. Sanders: [091-00:48] Let me just make a comment and then I think we have time for one more question. Dr. Rubin gave a list of potential reasons for the reduction. The one thing that I'm curious about and maybe at the end of the session later this morning we can hear again from Judge Specia but there's been an influx too of resources into the child protection system and I don't know if those resources have made a difference but I believe 3,000 to 4,000 staff started in about 2008 and so it would be interesting to hear from Judge Specia about his perception of that.

Dr. Rubin: [091-01:30] Yeah, I think the last question I have is sort of the increase again. This is the intersection question again. The increase in child welfare medical directors now and child welfare systems, the increase in child abuse pediatricians. On the nursing side you're seeing an expansion as well too. We heard from a nurse yesterday that runs a forensic unit. We haven't talked a lot about workforce. You elegantly showed your role not just as sort of providing direct services but how we come together as a community and try to provide vision for how we collectively work on these issues. Can you talk about the challenges of funding around child abuse pediatrics and child protection teams in general?

Dr. Girardet: [091-02:19] I'll start with that. It's a huge challenge. And part of the issue is that the vast majority of these kids don't have any funding other than Medicaid. They don't have private insurance. Several of them don't even have Medicaid insurance. In Texas we have a lot of uninsured kids. But then even for kids who have insurance that does not cover a child abuse pediatrician's time to go testify in court, to spend extra time sitting down in family meetings with CPS workers. I mean, all those things take an enormous amount of time and so there is absolutely no way that you can cover your costs as a child abuse pediatrician with a traditional medical billing model. The other thing is if we really want to provide effective services to these children they all need some level of psychosocial care. At least in our clinic and I know a lot of places, the social workers don't even bother to bill because you lose money if you try to bill Medicaid because it takes more time than it's worth.

So we don't even bother to have them try to bill Medicaid for their services. Most psychologists who see children don't take Medicaid patients because it's not worth their time to try and bill the system. So you have to have additional funding in order to provide those services. So again without the funding we wouldn't be able to keep our doors open.

The other thing that I just kind of noticed and this is totally anecdotally through our statewide network is the level of services in rural communities the way things are billed is very different from the way they're billed in a busy community children's hospital. So a child presents to a rural hospital down in the Rio Grande Valley with an isolated skull fracture. They never lost consciousness. They don't have any other problems. Down in the Rio Grande Valley they'll be admitted to the ICU for observation and they will be billed as an intensive care patient. In our hospital, we're lucky to get them admitted to the hospital for observation for safety concerns. A lot of those will be sent out of the ER. So when you're looking at data in pediatric intensive care admissions, if you try to look at that where injuries, that is very different based on where they are. So we have a lot of perverse messed up in the system.

Dr. Sanders: [092-00:00] I know Dr. Rubin's question was for all three of you but we're going to truncate the answer and perhaps you can have the conversation during the break and I want to thank the three of you for such an outstanding and informative presentation. Thank you very much.

So we're at the time of the break and we can reconvene at 11:25 with Part 2 of our Texas conversation.

[BREAK]

Dr. Sanders: [093-00:00] Let's convene once again. And for the next hour we have again similar to yesterday, as well as to earlier this morning, some speakers who will give us greater insight into the work in Texas and we ask speakers to focus on the counting of fatalities and what works and what doesn't. What the federal government can do and perspectives on confidentiality. We also will look to written testimony from each of the speakers. Again similar to yesterday, I don't want to ever be rude but we will adhere to the time limits because we have so much information that we're looking to gather. We have a couple of people who have either sent substitutes or will not be able to come, so we should have plenty of time for questions for each presenter. So we're going to switch the order and Judge F. Scott McCown who is the Director of the of the Children's Rights Clinic at the University of Texas Law School will present first and he will present for about 10 minutes and we'll have three minutes for questions.

Judge F. Scott McCown: [093-01:09] Thank you Mr. Chairman. The Protect Our Kids Act can be a catalyst for real progress, and I was just thinking early today what a missed opportunity it was 25 years ago when the presidential Commission on Child Youth and Death wasn't funded and didn't get to do what you're doing now. The Commission to Eliminate Child Abuse and Neglect Fatalities has a really heavy responsibility and I hope that you make a very powerful report to Congress. I've got one observation I want to make and three brief points. My observation is that the

Texas drop in abuse and neglect deaths needs more study and I'm very suspicious that we can draw meaning from that and I will explain why.

The three points that I want to make are that a powerful recommendation would be to separate the study of child deaths from the determination of child maltreatment and I'll explain what I mean by that. My second point is that we need to distinguish between agency confidentiality and public transparency. And then finally that the Commission needs to call for funding the fundamental reforms it identifies. So let me go to my first observation.

So in Texas in 2010 we had 212 identified abuse and neglect deaths. That actually went up not down in 2011 to 231 and then dropped by 19 in 2012; it dropped by 56 in 2013. Two observations about that. First, when a mortality rate is small, the smaller the mortality rate the more difficult it is to distinguish random fluctuations from actual changes in risks. And what we have to confront is the question, "Have there been actual changes in risks?" And I think a drop of 56 in one year, even followed by a drop of 19 the year before, doesn't tell us in a state with 7 million children, 2 million of whom live in poverty and if I did my math right last night 1.5 million that are three and under that we've changed the risk of death in Texas. Particularly when you look, when you peel that onion back and you look at the regional variation, Texas is a big state with a lot of kids. You look at the regional variation and most of the drop is accounted for by Houston and Arlington, two large urban areas who had a significant drop well below the state average, when many other regions of the state were above the state average. So I'm going to urge you to be cautious that something systematic has happened in the state of Texas.

The other reason I'm going to urge you to be cautious about that number is because it is a mediated number and you've heard a lot of testimony about the problem with mediated numbers. I want to refer you to a *New York Times* article in July 2013 about a very interesting study done by a Harvard economist. Between 2006 and 2009, child abuse and neglect cases dropped about 1 percent in the country. This corresponded with the Great Recession. And the idea was how could we have a drop in child abuse at the same time we're experiencing a great recession and all this economic stress? So what the economists did was a Google study. Just like Google predicts the outbreak of flu by looking at searches for flu medications and others. He did a Google study to look at the outbreak of child abuse and neglect and discovered that questions like, "Why did daddy hit me?" had skyrocketed during this period. In fact, using this Google analytical predictive, you would have said that there was a significant increase in child abuse. He attributed the lower official reports to cuts in state budgets during the recession. And so with any mediated number you have to be careful and with any small number you have to be careful. So I urge you to do a lot more statistical study before coming to any conclusions that things are looking good in Texas.

Quickly my three points, first, you really do need to separate the study of child deaths from a determination of child maltreatment and there's two reasons for this. Those are different questions. When we study child death we are taking a public health perspective. Why do children die? How do we prevent recurrence? Is it preventable? When we look at the determination of child maltreatment we're assessing the parents' conduct, and in that a couple of things happen. We look at culpability. We have some sense about fault. We're making a normative decision. Was the parent culpable? Was

the parent at fault. That's different from the question is this preventable. And second, when we make that decision we're talking about should the state intervene with other living children left behind. If we're going to call it neglect, does there have to be a state response? And we're always concerned about collateral consequences. For example, a public school teacher. If we call this neglect her licensure may be in jeopardy. And so when we make a determination of child maltreatment we have a bunch of things happening. Legitimate things happening that mess up the call on the public health question of is it preventable?

The second point is then if the public health question is a broader question it involves things like texting while driving, how children sleep, and the public health question is going to identify the need for improvements in parenting long before we would be willing to say that that's a normative value and that the failure to do that means that you're culpable of neglect. So like some of y'all right here I bounced around in the backseat of our station wagon without any seatbelt and my parents and that generation would not at all have been culpable. Yet that needed to be identified as a risk for children and we needed to address that through a public health perspective. At some point it becomes culpable because at some point it becomes part of the culture and part of what we require of parents. But we should separate the public health question from the question of culpability. If you do that then you don't have to, as Commissioner Bevan was talking about, you don't have to try to mess with the states' abuse and neglect laws. You don't have to try to mess with the states' intervention systems. You build instead a public health model of how we're going to analyze death.

Second point. In our agency, confidentiality means to be distinguished from public transparency and I want to echo what Commissioner Horn said that this is a lot more difficult than you may think. I want to disagree with a little bit my good friend Commissioner Petit, which is the problem with deaths is they don't produce in the public, we need higher taxes, we need improved systems. Instead they produce in the public, heads should roll. Perhaps heads you don't want to roll and they produce constant chaos. And so what you have to do is look at these problems as systems issues and the model I would recommend you think about is the medical peer review model. Where there is no confidentiality in your agency. You get all the information you need for the child fatality review but that doesn't necessarily mean that you have complete public transparency. That has to be carefully balanced and CAPTA makes an effort in the guidance to do that. There are also concerns about the rights of the parents, the rights of living children and frankly the rights of public employees.

Finally I want to say you need to call for funding fundamental reform and this is tricky because I know that this is a group about child fatalities, but it's abuse and neglect that kills. The fatality is in many ways kind of a random consequence. Many of the solutions are across-the-board fundamental solutions. This is a tired metaphor but if you've got a canary in the mine shaft and the canary is dropping over we don't talk about rushing a little bottle of oxygen to the canary and say the oxygen for the canary solves the problem. Right? The problem is a much larger problem and the concern is about all of the children for whom abuse may kill or seriously damage their life. In Texas our caseloads are too high. Our turnover is too high. We underfund foster care dramatically. We only cover 85% of the 2004 cost. We have a tiny prevention effort. So, what do you identify as being critical for abuse and neglect? Even in a tight budget

year? Even understanding the fiscal constraints? You need to call for funding fundamental reform. Don't just advocate that little bottle of oxygen. Thank you.

Dr. Sanders: [095-01:41] Thank you very much, Judge McCown. Commissioner Rubin.

Dr. Rubin: [095-01:45] This is Judge McCown? This isn't Dr. Lakey?

McCown: [095-01:46] Yes, I convinced Dr. Lakey to let me jump ahead of him.

Dr. Rubin: [095-01:47] I'm going to hold my question for Dr. Lakey.

Dr. Sanders: [095-01:48] Commissioner Covington?

Covington: [095-01:49] Give me your three best ideas for fundamental reform?

McCown: [095-01:51] Well, flexible funding even revenue neutral would be a significant accomplishment. And if you could get flexible funding where the state could reinvest the savings, that would be an even better accomplishment. If you could get flexible funding with a little uptick in amount that would be even better. That would be the number one thing. There are so many problems, I mean Commissioner Specia was just talking to me earlier today about the "look back." The title IV-A funding for the state is continuing to dwindle and putting states in a tough position. So I think some attention to funding issues that might could politically achieve y'all should push the envelope on that. That would be funding, funding, and funding.

Dr. Sanders: [095-03:02] Any other questions?

McCown: [095-03:03] Well, thank you very much. I appreciate it.

Dr. Sanders: [095-03:04] Thank you very much. Now we do have Dr. David Lakey, who's the Commissioner of the Texas Department of State Health Services. He'll have about 12 minutes, with 3 minutes for questions. Thank you Dr. Lakey.

Dr. Lakey: [095-03:26] Thank you. I'm going to hand out a quick report while I'm talking. Good morning, my name is David Lakey, I'm the Commissioner of the Texas Department of State Health Services. I work in our agency with the public health, the mental health, the substance abuse agency for the state of Texas. We do a variety of initiatives to improve health in the state of Texas. I have the privilege of working very closely with Judge Specia. I want to thank you for coming to Texas and thank you for coming to San Antonio today. Our agency supports the goals of the Commission to develop recommendations for a national strategy to reduce child abuse and neglect fatalities.

I think traditionally there's been a disconnect between public health and child protective services. We've been working in the state of Texas to try to minimize that disconnect to take care of the silos to work closer together, and I feel very privileged to work with Judge Specia over the last several years and with the Department of Family and Protective Services. I think the role traditionally for public health has been involved in data. Birth certificates, death records in light of child fatalities.

We have also been involved in preventive efforts in public awareness campaigns. Around such central public health efforts as infant safe sleep, child safety seats, and seatbelts. I think in recent years we have been working much more closer together through the Department of Family and Protective Services. In my little bit of time I have today I'm going to focus on three items. One is the importance of providing timely data regarding child abuse, neglect, fatalities in Texas. The second issue that I'm going to touch on is the critical role substance abuse plays in this whole area in the variety of challenges that we face in the Department of State Health Services. The third item I'm going to provide some emphasis on is the critical role that providers play that we can have in giving them the tools just our resources so that they can deal with complex issues.

So first let me talk about the child fatality review. Our agency works with the Department of Family and Protective Services. We've made a statewide effort to conduct a retrospective review of children's death through a volunteer phase child fatality review team. You may be very familiar with this. I've handed out the most recent report and we take this very seriously. From our perspective the child fatality review is a public health strategy to understand child deaths through a multidisciplinary review of the local data. Data collected and analyzed to better understand the risks that we have for children. The lessons learned from the reviews inform local and statewide activities.

There are two critical components of this overall review. There's the state child fatality review teams then there's the local child fatality review teams. Currently in Texas we have 76 child fatality review teams and they cover 203 of our 254 counties. It covers about 95% of the population in the state of Texas. They review about 60% of the deaths. Child fatality review teams conduct retrospective reviews of a child's death in their geographical area and these local reviews may be conducted a year or more after each event. So sometimes there's a delay in getting those reviews. The child fatality review teams identify risk factors specific for the communities. They monitor the trends. They spearhead local efforts. Our agency provides the training so they can be effective. We also work with the statewide team. I passed out the statewide to you. I think the importance there is that they take it seriously. They look at the data and they give us specific recommendations. The legislature looks at those recommendations.

For example if you look through that report, one of the recommendations that they've had for a while is that the Department of State Health Services works closely with the Department of Family and Protective Services to data match. So we've worked through how we do this between our agencies. They give us the data of parents that they've had to take custody away from. We look to see if there's been any new babies that have been born from those parents and we give them that information where they can have their teams go and look or nurses go into those houses just to see how things are going now that the new baby is in that house where there's been a child that's been removed from the past. A couple of challenges related to our system. One, is part of a manpower issue. Not having the ability to review all the deaths and not having them in all of the 254 counties in the state of Texas.

Next item that I want to emphasize is the role that substance abuse plays and the various challenges that we have in the state of Texas and I think this is just one aspect

of it. I think you are all aware of the challenges that substance plays throughout our nation. Prescription drug-related deaths now outnumber those from heroin and cocaine combined, and drug overdose deaths exceed motor vehicle deaths in 29 states and the District of Columbia. Today only 1 in 10 Americans with substance abuse disorders receives treatment, and untreated substance abuse by parents is a direct threat to their children and of course if unchecked took far too many of our children in foster care environments. Basically the point here is we're the substance abuse agency and there's a critical need for the folks that Judge Specia and his agency serves to get individuals into substance abuse treatments. There's been a gap, a delay in the past when they've gone into homes and they've seen that substance abuse is a major problem in trying to heal that family and being able to put kids back into that family. That delay really is a stumbling block. So going into the last legislative session we decided that we needed to work together to figure out how we could ensure that whenever they went into a family and substance abuse was an issue that we could get mom and dad and whoever else in the family into substance abuse treatment. So we got the support of the legislature—\$10 million was allocated last legislative session—so we could ensure that there wasn't a wait list in the area of substance abuse. So screening, assessment, treatment services expanded eligibility for pregnant and postpartum intervention for the Department of Family and Protective Services clients. A new fatherhood intervention were all part of that \$10 million initiative. Since December we've trained about 1,400 Department of Family and Protective Services caseworkers and we've also served more than 400 additional clients, and our target is that we'll get about 3,000 additional clients that will get into substance abuse services this year.

The third item in my limited time is the importance of provider education so that these frontline physicians can recognize when something is wrong. Our agency's efforts center around our program called Texas Health Steps; it's our state Medicaid program. Comprehensive Preventive Child Health Services is for individuals from birth to age 20. It focuses on medical, dental, and case management services and is dedicated to expanding the recipients' awareness of existing services, the recruitment and retaining of qualified provider pools, and we have an online provider education program that we work with and we work with on this initiative with the Department of Family and Protective Services to develop this program that pediatricians and other individuals can go to and get their continuing education so that they can recognize when there's a problem. So recognizing, recording, and prevention of child abuse and infant safe sleep. We believe that information to those providers is very helpful for them to recognize when there is a problem.

Again, in the very short time I have today I want to thank you for being here but again emphasize the importance of having good data and having the local input so that we can understand the data. Having the child fatality review system so that they can look at that data and decide what are recommendations that we can implement here in our state. I want to re-emphasize what a significant role substance abuse plays in the state of Texas and poor health and the need to have education for our providers. Looking at the agenda you don't have much time. But if there are any questions I'd be happy to answer any questions.

Dr. Sanders: [097-02:43] Thank you very much. Commissioner Ayoub.

Ayoub: [097-02:44] With the importance that substance abuse does play in this area, is there a reason that the seven recommendations that came out of the review team only had one that was connected at all with substance abuse?

Dr. Lakey: [097-02:46] Why was there only one recommendation?

Ayoub: [097-02:47] That connected to substance abuse.

Dr. Lakey: [097-02:48] I'm not sure why there wasn't more than one recommendation. From my perspective, substance abuse is a huge driver. There's always a hard sale to the legislatures to get the support you need. We've had increased recognition in our state. The problem for us, this last session was the first session in quite a while that we've been able to get additional support related to substance abuse. I think continuing education with fatality review teams, they look at all fatality reviews, all fatalities and provide that information. But my perspective is a little bit different than the overall drivers.

Dr. Sanders: [097-03:55] Commissioner Martin?

Martin: [097-03:57] So the importance of substance abuse in this area and I do agree with you a lot of our cases have substance abuse issues. Do you know what percentage of your deaths involve substance abuse of the parents?

Dr. Lakey: [097-04:10] I can't tell you the percentage of the deaths. I talked to Judge Specia about the percentage of his folks that he takes care of through the Family and Protective Services but it's a significant percentage of folks that the families that he is involved in have substance abuse. I can get that number for you.

Martin: [097-04:28] I understand that. I was just wondering whether or not when the review teams are reviewing the deaths, and we don't do this or I don't know if we do this in Illinois. I just wondered how many of the parents are the alleged perpetrators of the deaths that had substance abuse issues. Okay, thank you.

Dr. Sanders: [097-04:46] Commissioner Rubin?

Dr. Rubin: [097-04:47] Yeah, just to finish up this issue I feel like... forgive me because this is my first chance to talk to the state health commissioner since we started this, but I've got a couple of questions for you. The first question is just to finish up substance abuse. I imagine a lot of the substance abuse treatment in this state, particularly for folks who aren't insured, is coming from state budgets. I think this begs the question, the Medicaid expansion through the Affordable Care Act would have provided a tremendous amount of treatment services. For me and whether you want to opine on that it might be a little tricky. I think the idea of treatment services is exactly what we need to be thinking about. I think it's unbelievable to me that you have an expansion here where you could potentially have renewed resources instead we're depleting whatever limited state budgets we have for substance abuse. Any comment on that?

Dr. Lakey: [098-01:36] I'm not going to delve into the midst of politics related to expansion of Medicaid in the state of Texas. Obviously it's very complex and a lot of

issues have been related to that issue. My role, trying to expand substance abuse treatment services is my priority in my very large agency and so we've done several things. One is making substance abuse a Medicaid-eligible benefit, so folks can get services through Medicaid. Second, is the expanded access and I guess I would say even if Medicaid was expanded in the state of Texas you would still have a large number of folks that would not meet Medicaid or exchange eligible. So, we have to continue to see the whole breadth of the challenges of substance abuse.

Dr. Rubin: [098-01:37] I just have one more question. Let's flip topics. I imagine you have managed care penetration here for a lot of the kids on Medicaid across the state. Correct?

Dr. Lakey: [098-01:50] Texas has gone to basically 100% managed care organization.

Dr. Rubin: [098-01:52] So the opportunity to whether, to mean this is unrelateable to the Affordable Care Act. This is just where the markets are going with the movement toward managed care, movement toward population health. There is an increased focus now on managing population of children as it pertains to this issue. I've done work in the state of Pennsylvania in the Commonwealth of Pennsylvania where we know there are claims with young children, which have multiple injuries. How can you potentially work with your managed care organizations to have them take risks to identify children who have multiple injuries to ensure that there's a coordinated response. Not necessarily a CPS report on the basis of claims but that there's a well-being check on children or similarly to monitor almost like a new pediatric quality measure how often children are seen with failure to thrive. Some of those cases are the cases that we're talking about here today. Kid gets seen failing to thrive, low weight, and isn't seen again for a year until somebody picks up the fact the child died of malnutrition.

Dr. Lakey: [098-03:50] A couple of comments. First, understanding my agency. I'm not the Medicaid agency. So some of the intricacies of the managed care organizations that devise a treatment etcetera, really isn't in my realm. What we do though is I set, for the last several years I have a quarterly meeting with the medical directors of the managed care organizations in the state of Texas. With the premise that all of us benefit if we improve health in our state. So there's been areas of concentration, prematurity, infant mortality, those type of things but that I think those types of forums are areas where you can have those discussions and figure out where they can all work together on this type of initiative. The intricacies of changing Medicaid policy would actually be in another part of Texas state government.

Dr. Sanders: [098-03:52] We'll take one last question then we need to move on. Commissioner Covington?

Covington: [098-04:46] It's a comment, actually. I hope the Commission some time will spend some time really looking at what child death review is and what its power is to be able to understand fatalities. You just lost your coordinator, she took a new job but I can't give you enough kudos for what happened. Texas made a shift from having child fatality review in social services over to public health a number of years ago. In the Senate though, they legislated it. I think what it did is it really allowed a broader focus on looking at all preventable deaths, which helps identify maltreatment cases

because of that. And the other thing, Texas has one of the best state job review advisory groups in the country. They really are proactive about pushing for legislation and getting legislation passed, so kudos to Texas.

Dr. Lakey: [098-04:57] Well, thanks. That credit goes to the folks that are part of that. Both in disciplinary review, sheriffs, police officers, law enforcement help all working together.

Dr. Sanders: [098-04:58] Thank you very much. The next is William McManus, Chief of Police for the San Antonio Police Department. Ten minutes for Mr. McManus.

Chief William McManus: [099-00:12] Are you all from Washington?

Group: [099-00:14] Everywhere. All over.

Chief William McManus: [099-00:28] Well, thank you all for being here. I missed the reception last night. I was tied up in another appointment but I'm glad you all are here. This is a topic of extreme importance not only here but everywhere. I'm going to go way off my script and talk about the issue as I see it personally. I've been in law enforcement now for 40 years. Started back in Washington almost 40 years ago as a police officer with the D.C. Metropolitan Police. I've seen wonderful advancements when it comes to dealing with child abuse. Those advancements when it comes to dealing with child abuse and those advancements come primarily from a network of agencies that are now involved in trying to prevent child abuse. Police cannot arrest this problem away. We deal very well with it in the aftermath. Arresting the violator, prosecuting in court, the DA filing through the court system and all. From a prevention standpoint we rely on information from the public. In relying on information from the public it's our job, at least in part, to help educate the public on reporting things that you see. A lot of people don't want to report because they don't want to inconvenience the police with information that may not be accurate. So they don't report it. We encourage them if you see it, report it. It does not inconvenience us one bit. So education is a big, big part of preventing child abuse. Dealing with family violence is also a big, big part of dealing with child abuse because if you have family violence in the picture there's usually kids involved and they're usually going to be caught up in that problem. The network of services that we have here in San Antonio is, I don't think is second to any city in the country. We have great people in charge. Judge Specia for one. You couldn't find a more dedicated individual when it comes to dealing with this issue. So we have a good person in place there. I talked about public education, public awareness being key. We've done PSAs. I've done PSAs on trying to raise the awareness of the public on reporting how important it is to report what anyone might believe to be a case of child abuse. Part of the problem is resources in these agencies that deal with prevention of child abuse. We don't have enough resources to go around. There is no requirement to be a parent. There is no educational requirement. There is no requirement that you take parenting skills to have a baby. There is no requirement that you do any kind of follow-up after the hospital to make sure that you know how to care for your child. Something as simple as putting a baby in a bathtub and not realizing that in one second that baby could go under and drown is something that a lot of people are not aware of. You don't need a resumé to present to anyone in order to have a baby. Anybody can have one and it doesn't matter what your social or economic background is. It doesn't matter what

your ethnicity is. It doesn't matter what your education level is. If you want to have a baby, you can have a baby. Therein lies part of the problem because there are people having children that don't have the knowledge of how to deal with one. That's where we come in as agencies, as a network in helping to prevent child abuse. So, that's kind of my pitch from the police end of it. Again, our role unfortunately is in the aftermath of it. Once it's reported. Once a fatality occurs. We've had two so far this year. We had two all of last year. But we've already met that number this year. So, my big picture is education, public awareness to try to prevent child abuse.

Dr. Sanders: [100-00:48] Thank you very much, Chief. Commissioner Petit?

Petit: [100-01:50] Thank you very much for that overview. Let me ask you in response of the point you were just making about the aftermath, the police coming in after something has occurred. What about pre-emptively in terms of the department suspecting a dangerous caretaker is in the household. Someone who may have a history of abuse and neglect. Maybe he's coming in from another county, another city, another state on this thing. Has a history of broken bones and may well have shared time. Then you have a 25-year-old social worker who the case has been brought to their attention. Do the police accompany CPS investigators, in the CAC process you guys participate in, would my saying as a social worker, "listen we've got a case we think is a very rough case right now. We're suspicious, we're not certain but the guy has a history." Would the police participate in that, and do you guys have protocols for how you involve yourselves with CPS?

McManus: [100-01:58] We will participate and if are requested to participate by CPS we will abide by all means.

Petit: [100-01:59] Then there's the issue of across the country of prosecutors complaining that frequently police investigations don't comport with certain requirements that they have to meet in order to successfully prosecute somebody. Are there memoranda of understanding here between police, prosecutors, CPS, emergency medical rooms? How do you guys work that?

McManus: [100-02:20] I don't believe we have a memorandum of understanding with the DA's office on dealing with these issues. We simply haven't had those issues come up and I haven't signed any kind of MOU with CPS. We work very closely together.

Petit: [100-02:40] Do you have a unit of individuals within the police department that are especially trained to work in this area that are assigned to CPS?

McManus: [100-02:48] Yes, we do. If we are on the scene of a complaint of child abuse, the police officer suspects it, sees it, we will call CPS. We will call somebody. We will take that child out of that situation if the officer feels that the child is in danger. If it needs to be done immediately, we will do it immediately.

Dr. Sanders: [100-03:15] Any other questions for Chief McManus?

McManus: [100-03:17] Thank you very much.

Dr. Sanders: [100-03:28] Thank you very much. So we're also fortunate to follow that with Krista Melton, who is here for Judge Susan Reed who is the criminal district attorney of Bexar County. Ms. Melton shall have 10 minutes and a couple of minutes for questions. Thank you.

Krista Melton: [100-03:48] It is a pleasure to be here with you today. I am here representing the elected District Attorney Susan Reed. I am a member of her staff, I am an assistant criminal district attorney. I've been in the Family Justice and Victim Protection Unit for approximately 14 years. What I do there is what all of our DA's in that section do, we focus on child physical abuse, child sexual abuse, we do adult sex cases, and we handle family violence from assaults all the way to capital murder. So we handle all the baby death cases that come through San Antonio as criminal offenses. We also handle all the child injury cases, and in the last four years we have also taken on the issue of human trafficking, which includes in this jurisdiction primarily domestic minor sex trafficking, which is of course an extreme form of child abuse in itself.

So, from our prospective when you come to the issue of child abuse it is, from my perspective of course, the most critical issue in San Antonio. Unfortunately we have some rough numbers, which I'm sure you all are aware of. We have a significant amount of child abuse in our community. So the issue of prevention is near and dear to our heart. And something that we work every day to try to make a difference in. You've heard from many different organizations. We are kind of at the end of the game. We get that case once it is filed by the police. There are certain cases where we are brought in earlier in the investigation. If there are legal questions that need to be involved or if there is some sort of discussion that needs to be had but typically cases come to us in the form of a case jacket that's filed with the investigation completed. We then receive that case, do whatever additional investigation that we can to prepare the indictment. Take it to the grand jury and the case is placed on a docket.

Now our interaction with these various agencies does not stop at the point where we file an indictment, obviously. We are talking with CPS throughout the process when there are CPS workers involved. We are talking with the police throughout the process. One of the most important resources for us as prosecutors in this area is the Center for Miracles, who I believe you heard from Dr. Lukefahr earlier today. The Center for Miracles is critical for us because especially in child fatality cases we have to go to the doctors before we can even begin to decide what to place on an indictment. So they make their expertise available to us pre-indictment as well as post-indictment, and then they are the folks who come in and testify in our cases when those cases have to go to trial. One of the things I wanted to tell you about is just something that I've seen in the course of my 14 years. I have trialed multiple baby death cases and pled several others. The scenario that I see in this jurisdiction happening over and over again is very young people having children. They're unprepared. Most of them are not married but they live together in some capacity. Typically the mom is either in school or working and the dad is not. He is at home and he is caring for an extremely young child or infant. In that situation we see over and over again an inability to care for the child's most basic needs. Dad typically knows three things. If the baby cries I need to change the baby, I need to hold the baby, or I need to feed the baby. When that does not stop the crying what we ultimately see is a

fatality situation or a near fatality situation where that child is slammed up against the wall, hit on an object, kicked, or abused. That ends up with abusive head trauma. It ends up with any number of internal injuries and often ends up with a fatality. So what are some of the issues that can be addressed by this Commission because my guess is we're not the only jurisdiction with that pattern. We've got some fundamental underlying issues that are huge. They are monstrous. When we are talking about child pregnancy. Teenagers having children and then being unable to care for them. We have massive issues when we're talking about unemployed dads who end up as the child care person. So the lack of appropriate child care for those babies. We are also talking about an inability to manage emotion or anger which of course is going to show up in every family situation. Those of you who have had children or have been married you know what I'm talking about. Anger is something that we all have to do deal with and if you don't learn in any capacity to deal with it because you didn't learn coming up as a child then you are going to have that same problem as a parent. You are going to be ineffectual and perhaps violent in a rough situation. So I see those as some of the major issues.

Tools that I'd like to see going forward when it comes to dealing with child abuse. Texas has some really great laws on the books when it comes to child sexual abuse. We have something called Continuous Sexual Abuse of a Young Child. That law allows us to charge a defendant if he has committed two or more types of sexual abuse in a period of 30 days or more against one child or more than one child. If the child is under the age of 14, we don't have to prove anything other than that period of 30 days or more as far as date, and it allows us to charge more than one victim in one indicted count. I would like to see that available for child physical abuse as well. I would recommend that would be something that's available in the federal law when a federal prosecution is appropriate. Although most of the time, as you know, child abuse is being prosecuted at the state level. I'd also like to see a child torture statute. That's something that's been coming up in the medical field. They've been working on that as a diagnosis, but I think it needs to be an actual criminal offense. Because we often have cases that may ultimately lead to a fatality but we can charge it a whole lot more significantly before it gets there if we had a statute like this. Let me give you an example. We have a child who was being tortured. She would be not fed on occasion. She would be placed up against a wall. She would be physically abused at times but not to the extent that it got us to what in Texas would be a first-degree felony in Texas. In other words a serious bodily injury, but over the course of time she rubbed holes in her chest just self-massaging herself. She went from being a child who was able to speak to being a child who was no longer able to speak. She was losing her hair. She was losing the ability to function because she was shutting down because of the constant abuse. That child eventually died in an abusive situation where she was hurt to the point of death. Had we been able to get that case earlier and not charge what we would normally be able to charge would be only a third-degree injury to a child, causing bodily injury, but we were able to prove that pattern we could have perhaps stopped the fatality. So that is something that I would recommend and I would really like to see.

We are part of the Child Fatality Death Review Board both at the local level and the regional and state level, and that is an extremely critical part of the fight against child abuse in our state and in our locale, and we have had several laws that have come as a result of that. We've also had some innovative public awareness campaigns that have

come as a result of the Child Fatality Death Review Board. Because not all child abuse ends up being charged as a crime. Some of it is deemed to be an accident. Some of it is deemed to be a personal tragedy in a family and yet that child is still dead. So one of the innovative things that have come out of our Child Fatality Death Review Board is a water campaign and a water watcher campaign. Where we have had so many, because of the proliferation of pools in Texas, the fact that it's hot and people want to swim, we have kids drown all the time. Very young children. We have created a public awareness campaign that's part of many different agencies that was headed up by Any Baby Can and a whole group of folk that is designed to bring out the parents that are paying attention. You need to be watching your kids in the water. So I think there needs to be a combination of legal strategies on the criminal side as well as a combination of public awareness campaigns targeted at people perhaps who aren't necessarily abuse their children but may be prone to neglect that ends up in a fatality. So I am available to take your questions if I can in any way.

Dr. Sanders: [102-2:42] Commissioner Ayoub?

Ayoub: [102-02:53] As a trafficking survivor I thank you for making the connection between trafficking and extreme child abuse. Thank you. Of course if it's a familial trafficking situation and there's a death, that would be under [inaudible]. Have you ever seen or heard of something where child abuse led to the child running away and then being killed by a trafficker, pimp and also having a charge of child abuse on the parents?

Melton: [102-03:24] I am the human trafficking prosecutor and I also head up the ongoing coalition against trafficking here, which is a combination of law enforcement, academia, and our nonprofit community. What I have seen as far as trafficking is a large number of our domestic minors are running from abusive situations at home. That's the first thing. We have not had any cases yet where we have had a fatality as a result of that trafficking in this jurisdiction, but I'm sure as you know the statistics show that if you are not rescued out of the life, the average lifespan of an individual involved in trafficking is eight years. So we are talking about people who are going to be engaged in fatal situations. What we have had is kids who have been trafficked, who have run from abusive situations, were placed in CPS care, walked out of CPS care because CPS cannot force them to stay there, ended up on the streets of Houston originally then was brought here. Once she was here she ran from care. She was in a juvenile facility, ran from care, and at that point she began being pimped out here. Her pimp abused her. She ran from him, ended up meeting another guy who was not a pimp but who her original pimp thought was a pimp. And he forced her to bring that guy in under the threat of killing her. He killed him in front of her and the 16-year-old witnessed that murder. So we do have situations where that child is clearly in a position of either her own life on the line or having someone else's life on the line and then having to witness that murder.

Ayoub: [103-00:05] So in that case if a pimp killed the girl would you look at the child abuse from before she ran away or would it stop there as a criminal case?

Melton: [103-01:18] Well, in that case the child abuse would have been in another jurisdiction so it wouldn't have been something that I could do. One of the things that I think would be extremely important would be the ability to have a much enhanced

communication between jurisdictions not just statewide but nationwide. I know that earlier you all asked one of the speakers a question, “if somebody comes from another jurisdiction they’ve got history there.” If they have a criminal history we can look it up. What if they have CPS history? Getting records from some other jurisdiction is not something we’re going to have. One of the things I think you will find in your work here is that abusers often simply skip town. They just leave. If there’s a situation where they’re under CPS stricture they just move out of the jurisdiction. CPS is then forced to close the case. They can’t go somewhere to another state to find them, and I think there is a huge need for enhanced communication there and then an enhanced ability for law enforcement and for district attorneys to be able to access that information easily.

Dr. Sanders: [103-01:19] We’ll take one last comment, Mr. Horn.

Dr. Horn: [103-01:21] So criminal laws is not something I know very much about. I need a little education and the question may just be a stupid one, so do be kind. It sort of makes sense to me that there are instances of physical abuse that lead to criminal charges. What about neglect? Is there something called criminal neglect and what is it? If so, do you ever prosecute it and what is the threshold for criminal neglect in case of a child fatality?

Melton: [103-01:55] We have a couple of options. We have an actual injury to a child. If it causes only bodily injury, which is pain, illness, or impairment, that is a third-degree felony. If it causes serious bodily injury that’s going to take it potentially up to being a first-degree felony. We have endangering, which would be where the child doesn’t actually get injured but could be in danger. Essentially that’s the definition of endangering. That’s only a state jail felony and it carries a penalty range only up to 2 years in a state jail. We also have abandoning, which often goes hand in hand with endangering. So mom’s got five kids at home all under the age of 7, mom’s had it, locks them in the house and goes to drink at the Taco Cabana. Okay, that is not an unheard of scenario here. When that happens that can be charged as abandoning or endangering, both. Depending upon the circumstances. Do we have something called “just neglect,” no we don’t. Do I think it could be very helpful? Yes. I also think it could go under a child torture statute where you have this constant either inability of the kid to access food when they need it. Inability of the child to be taken care of on a regular basis. Not enough clothing. Not a home that’s providing a shelter over his or her head. I think it would be helpful for us to have something like that but technically for us that neglect has to fit under either the injury statutes or the abandoning and endangering statutes on the criminal side.

Dr. Sanders: [103-03:034] Thank you very much, Ms. Melton. Very informative. Next and I’m probably going to butcher the name, Dr. Jolyn Mikow, faculty, University of Texas at San Antonio. Welcome.

Dr. Jolyn Mikow: [103-03:52] Thank you. I’m on the faculty here with the Department of Social Work at UTSA, and I know we are all here today because we recognize child death as a national problem. I, in a former life before I became an academic, was an employee and a supervisor, I did direct service work and I supervised people who did that direct service work to CPS. I was one of those workers that had a child death on my caseload. I supervised other CPS workers who had child

deaths on their caseloads. I know the struggle and the pain that the family and the community goes through, but I have seen it from the worker's point of view as well. One of the reasons I pursued my doctorate was to in some way impact the system and in some way improve services to the families and in some way improve the training to the public child welfare workers that assume these positions and go out and do the investigations and work with the families.

So as far as my recommendations to you today, I have two that I will talk about. The first is funding meaningful prevention and early intervention programs. The second is to address the training and education of the public child welfare workforce. Prevention needs to become a priority. Not the first place to cut when the budget gets tight. Prevention should be a primary focus to address any effort for child death. The incidences of child abuse and neglect many times far exceed the system's capacity to handle it. Many times when I knew that the workers I was supervising were stretched to the max and there wasn't any way they were going to get around to all those cases and see through the details to they needed to eliminate the risks and address the issues because we simply didn't have the workforce. Abusive and neglect investigations by their very nature are adversarial and focused. Many times they are conducted well after the window of opportunity for change in that family. So there needs to be a demonstrated real level of commitment to prevention, particularly in the state of Texas. It is a tiny small sliver of the CPS budget. I have worked with prevention and early intervention programs with the agency and they are always pinching the penny and they never have enough.

The second issue that I want to address is the education of the public child welfare workforce. There is a little-known part of title IV-E and IV-B of the Social Security Act that funds the training of the child welfare workforce but also funds both employees and students to get a social work degree and they become captured employees to the public child welfare workforce. As you may be aware, there are several different levels of service in public child welfare. You have investigators. You have family-based services. You have conservatorship workers. You have workers that work with populations that are emancipating out of foster care and all other kinds of levels of work. At every stage of service, the risk of child abuse and the risk of child death can occur. For title IV-E funds specifically, and I administer that program here at UTSA, those funds are focused on providing stipends to pay for CPS employees or students in their advanced coursework to become CPS employees, and they become captured for a certain period of time based on the number of stipends they receive. The stipend pays for tuition and fees. The reason this is relevant is because studies have shown that those with a social work degree are more committed to the client populations and specifically when it comes to the child welfare workforce they stay longer and they have better case outcomes. One of the big problems of any public child welfare workforce, but certainly we've experienced this here in Texas, is the fact that the retention rate is so incredibly low. You spend a tremendous amount of money training an employee and the employee they will stay up to about two months they will be there for five years. The problem is this is not work for the faint of heart and it's not work for somebody with a Spanish degree. I've worked with those workers. We deprofessionalized the workforce. We have people who are not committed to child welfare and social work populations working these cases. They don't know what they're seeing. They don't know what they're looking at.

Across the United States, universities have title IV-E programs. Depending on what state you land in you may or may not get a stipend based on your level of employment at the agency. In Wyoming and Nebraska any CPS employee can get support for getting this education. In the state of Texas they have interpreted this very restrictively so only those workers that have direct contact with foster kids can gain a stipend to get the education. Now this leaves everyone that's going into a home working with family and any investigator out of eligibility. Investigators see primary risk for child death almost every day when they enter a home, and yet they're prevented from getting this education by the way it's interpreted. The interpretation on who can get these funds varies widely across the United States. In addition to that, because of the Budget Reduction Act, the amount of money that universities are reimbursed for providing these programs has dropped by over 60% over the last four years. What has happened is the entire state of Georgia has shut down every IV-E program. There are no more CPS workers that are social workers going into that public child welfare system. Florida has done the same and there are many programs that are going to be disappearing. Pennsylvania is kind of shaky. We have a national conference here in Galveston, Texas every year of all IV-E programs across the United States, and there are half the number of attendees because of the budget restrictions and the poor reimbursement rate we are getting. If I can ask you to do any one thing I would ask you to advocate for restoring full funding to these stipend programs. An educated, well-trained child welfare workforce would make a significant impact on child death. Thank you.

Dr. Sanders: [105-01:42] Questions or comments from Commissioners? Commissioner Bevan.

Dr. Bevan: [105-01:44] I have two questions. Number one has to do with we're trying to look at programs that work. What's effective. What do you consider a funding a meaningful intervention and prevention program? What does it look like?

Dr. Mikow: [105-02:09] First of all, there is a mandate to provide prevention programs that have shown to be evidence based, and one of the problems that I have noted in working with prevention and early detection here in the state of Texas is they don't have a clear understanding let alone an embrace on what truly evidence based is. And there is some discussion within any of the social service disciplines on how do we prioritize and how do we determine what is a higher level of evidence from a lower level of evidence. The federal government even itself has developed some evidence-based websites where you can look at interventions, but they vary from department to department and they vary from what they consider good evidence to poor evidence. In addition to that, though as far as the funding for prevention in Texas, it really needs to be double what it is now if not more.

Dr. Bevan: [105-03:20] But what are we doubling it for?

Dr. Mikow: [105-03:21] These are the prevention programs that when CPS goes out and does an investigation and there are a lot of risk factors but abuse and neglect have not yet occurred. They are parent education programs. We have a significant number that are funded by the Kronkosky Foundation here in San Antonio, and they are sometimes parent educators who were subject to the same kind of problems, parenting when they were younger so they are more of a mentor or there are other

educators trained and they deliver parent education. We have nurse-visiting programs that are run out of one of our children's shelters.

Dr. Bevan: [105-04:11] Do these nurse-visiting programs have nurses?

Dr. Mikow: [105-04:13] Yes, they go in and work with primarily teen parents.

Dr. Bevan: [105-04:16] Okay. My other question has to do, I also teach social workers. The funding for IV-E is 75% of the training.

Dr. Mikow: [105-04:29] It's 75% of certain parts. It's very complex. Fifty percent of others. The 75% is then multiplied by the child penetration rate and that's rate the federal government sets for each state based on the number of children that are eligible for AFDC.

Dr. Bevan: [105-04:53] Okay so it existed in 1996. So we have the problem of look-back, is what you're saying?

Dr. Mikow: [105-04:55] Yes.

Dr. Bevan: [105-04:57] The look-back affects the 75% training money. That's where you said that you're not getting the training, not because what I thought it was, it was that the training dollars are there but it's not because tuition has gone up. It's because of the IV-E.

Dr. Mikow: [106-00:29] It's the IV-E reduction in the reimbursement.

Dr. Bevan: [106-00:33] Okay and the drop in funds.

Dr. Mikow: [106-00:35] Right.

Dr. Bevan: [106-00:38] Okay, that's what I wanted to make sure.

Dr. Mikow: [106-00:41] And the other thing, the drop in foster care.

Dr. David: [106-00:43] We have one more question.

Dr. Horn: [106-00:45] First of all, as someone who started his career as a frontline caseworker in the local Department of Child and Family Services doing homemakers services, now family preservation services, I want to thank you for your commitment to training the next generation of frontline case workers. My question is given the topic of this Commission about child fatalities. Tell me a little bit about the curriculum that you use in training future frontline caseworkers around child fatalities. Is there something that you do to help them identify high-risk situations? Tell me a little about the curriculum that's focused on child fatalities.

Dr. Mikow: [106-01:28] That occurs in several parts of our curriculum. One of the issues in child fatalities is anybody looking at a child, particularly a young child who are at the highest risk, needs to know normal from abnormal behavior and that is child development. We do a lot around child development and development over the life

course. We also focus on obviously risk and protective factors in the training we do. We also focus on family systems and the parents, their history and what they've experienced impacts how they see their child and how they parent their child and how they nurture their child.

Dr. Horn: [106-02:08] Thank you.

Dr. Sanders: [106-02:10] Thank you very much. Thank you for your presentation. We'll close out with each of the remaining speakers will have four minutes with a minute for questions, and so first Reverend Dr. W. Raymond Bryant, who's a pastor of the Bethel African Methodist Episcopal Church. Thank you very much, Reverend Bryant.

Reverend Dr. W. Raymond Bryant: [106-02:40] Good afternoon to the Commissioners and to the Commission. I want to first say that I'm delighted that a Commission has been created and that serious work is now being done in the area of child abuse and neglect. Since I only have four minutes that's all I can say about that. I have really two concerns and then I will tell you some of the things that we do that I believe make a difference. The first concern that I have is that when you talk about neglect, the mother works three jobs, has no money for child care, barely has money for food, does all that they can to make it and I know this is true because one of the things that we did was we've done ethnographic research and actually adopted families working on their budgets seeing how much money they have. What they can do and the family that we adopted actually came up \$400 a month short. Every month. So there's no money for any of this stuff. There's no money for child care. That mother who works three jobs works 18 hours every day is treated the same way a crack head is in court when they leave their children at home. There's no difference in how they are treated under the law. That's not right. I think that you have to give some consideration to the real situation that people find themselves in and when they are in a no-win situation already then to take their children because they do leave them at home. They have no place else to leave them. That's why we have scouting programs and other programs we have in our church to try to help with that. That's why we do homework and everything else for them because they have no place else to go. If there is not something created for them then there's no way that they can really be helped but that is neglect. But if they don't neglect them then they can't feed them. Catch 22. So when you put people in that position it's very difficult and so there has to be something different and the law many times does not demonstrate wisdom or the persons who actually implement it demonstrate no wisdom whatsoever when it comes to these cases. I think it's important that real consideration be done and that it's actually done legislatively as much as possible, but wisdom cannot be legislated. I understand that.

The other thing that I think is important is that I always understood that there's at least two ways to deal with things when people are falling off a cliff. You can either build a fence at the top to keep them from falling or you can put an ambulance at the bottom and carry them away as they continue to fall. With the creation of this Commission, it was my hope that we were going to start building some fences but everything that I hear is pretty much ambulance at the bottom of the cliff. I think that in order for us to really make a difference we have to build more fences at the top of the cliff and I'm not hearing that. I'm not hearing it all and that's kind of frightening

to me because I have high hope that things are going to be different and that this Commission is going to help us turn the corner and make a difference for those who struggle so much in our society. One of the things we do at our church we actually, well I preach sermons about child abuse. Several years ago, I had an eight year old come to me and tell me, "My mother beats me." I said, "What?" "She beats me." Now I could have said the same thing probably when I was eight but it was a serious problem and so I talked to him, I talked to the mother, and we went through a whole series of events, and she didn't have him for about six months because it was true. After that, we started doing parenting classes in helping parents understand. But she was beating him because she couldn't help him with his homework. She was trying to do homework.

Dr. Sanders: [107-02:41] Reverend Bryant, a little over time now.

Bryant: [107-02:43] Well, my stories are short but I think the issue is there has to be things. You got to have places where people can go. You have to have places where you can help kids. You have to have places where you can help parents understand how to help their kids. All of those things are necessary. So I think it's important for us to make sure that as we're doing this we're not just putting the ambulance at the bottom of the cliff.

Dr. Sanders: [107-03:16] Reverend Bryant you had mentioned some of the things that your church does that would be a real interest to the Commission to get those in writing if there are some things you can provide to give us some ideas of what those fences look like. Thank you. Next we have Clarissa Zamora, is the Director of Education and Outreach at ChildSafe.

Clarissa Zamora: [107-03:45] Thank you for having me here. ChildSafe is San Antonio's local child advocacy center and we are doing some education programs that we are very excited to talk about. One is our initiative with our school districts. There are 16 school districts here in San Antonio, Bexar County. That's a lot. ChildSafe we have educated over 4,000 educators on recognizing, reacting, and responding to child abuse. Our endeavors continue to grow and grow and we're hoping to reach more. Our focus is to make sure that the community is aware of what's going on. I think it was Chief McManus that says the mother doesn't know that just turning away in a bathtub could cause a fatality. So we are out there not just educating parents but we're educating community partners, we're educating educators, we have an initiative with the YMCAs to train every staff member through our Stewards of Children program which is through Darkness to Light, an evidence-based child sexual abuse [prevention] program. So we are training every staff member. We are working with the Girl Scouts currently on providing the Stewards of Children training as well. As well as partnering with Haven for Hope in providing a child empowerment safety course called radKIDS, resisting aggression defensively. It's a 10-hour safety course that educates children, not just teaches them we don't just show them what to do we teach them so they know how to react appropriately to animal safety, gun safety, fire safety, bike safety, bullying, cyber-bullying, and then we talk about tricky people who want to trick you to do things you don't want to do and some of them have problems with touching. In that every 10 minutes this child is up doing a physical tactic to help this child break away in case of an abduction but likewise to be able to break away from the scene to run and go tell to wherever their safe place is. Safe place could be the cashier at Wal-Mart.

Safe place could be their teacher. We know that only one in 10 children will have the courage to come forward and say “Someone’s hurting me. Will you please help me?” So while we also want to encourage and educate adults we also want to encourage and empower children. So those are some of the neat initiatives that we are doing with ChildSafe. We continue to work with partnering agencies. We continue to offer educational courses to our multidisciplinary team partners who are law enforcement, child protective services, assistant district attorney’s office, and we are excited about what we are doing out at our child advocacy center. Thank you.

Dr. David Sanders: [108-01:46] Thank you. James Castro, CEO of St. Peter-St. Joseph’s Children’s Home.

James Castro: [108-01:52] Commissioner Sanders and the rest of the Commissioners, thank you for being here in San Antonio, Texas, and Judge Specia for being here and sticking out these two days. We appreciate all of you. The presentation I have before you I’m going to fly. This is just who we are. We’ve been around about 130 years. When I talk about and give you my key points I’d like you to think about that I’m proposing what we’re doing at St. PJ’s is impacting and going to reduce child abuse and neglect. Going to the next slide these are just all the programs that we currently have in place. The next slide, this is what I’m going to use to make my point. That is we all know that children who have been abused and neglected they have the highest subpercentages of a bunch of ills that we suffer in our society. Twenty-five percent of teen pregnancies, 30% of all abusers end up abusing, 77% of male inmates report past abuse or violent crime, and 90% of convicted murderers in the U.S. were abused as children. So as some of our panelists said this yesterday, are these predictive factors? And if they are, why aren’t we doing more to heal children from abuse and neglect in the first place. So that’s what I’m offering here at St. PJ’s Children’s Home. We have a process that we believe will heal children; thus, we’re going to break the generations of abuse and neglect that have been occurring in our country. Dr. Kathy Fletcher yesterday she mentioned that half of Haven for Hope homeless report being in the foster care system. So going to my next slide. How are we going to get there? I believe that we need to address the abuse and neglect, the trauma issues with the same urgency that we do for their physical well-being and for their health well-being. We need to have the same response to their emotional, psychological well-being. Currently we do not. We respond very subjectively based upon a CPS worker, based upon an ad litem, based upon a CASA worker, based upon a judge; there is not a four-month standardization of the type of care, and when we’re going to get that care to children and how to address their issues to begin the healing process. Judge Sakai offered one solution yesterday too. Judge leadership. I believe San Antonio is where it’s at because of the work of Judge Specia and Judge Sakai, as well as Montemayor and Garcia here in our city who have taken the leadership and are making a huge difference.

St. PJ’s realizes this urgent need and this is something that we’re trying to bring here to San Antonio and eventually to Texas. So with my remaining time here, these are some of the key points that I think needs to occur and we call it our 14-day model of healing.

One, we have to accept that fact is we have to have the same urgency to address the traumatic impact of abuse and neglect as we do the physical well-being. Two,

agencies like us need to have access to the bio family. We don't need to get involved with the allegations or anything like that but I need to talk to that bio family because I need to know the developmental milestones of that child so I can have some sense of how the trauma of abuse and neglect has impacted their developmental healing or their growth and all that kind of stuff. That needs to be a norm I believe across the state. Therapists and case managers for us have to complete all of their assessments by the 10th day. Then we create a global intervention plan that gives us the specific interventions that begins the healing for the child. I'm not just saying get him to a counselor or a psychiatrist. I'm talking about interventions that are going to help with the development of those impaired parts of the brain that have been impacted due to abuse and neglect. We believe if we can do this then the final thing is we have to empower the caregivers. Let us then train the foster families, the bio families, the kinship families, the adoptive families, whoever they may be on how to deliver the interventions for this child that is going to initiate the healing, and should this child have to be moved to another placement, let us train that next provider or that next home as well on those interventions. We need the plan to be able to follow the child. Because what happens currently often is when the child is moved then there is a whole new plan that develops. Let's stick with the same plan. Let's stick with trained providers who have the ability to know what that child needs and let's work with the system as much as we can. We are partners with CPS, with our judges in our courts, and so that's all I have to say about that.

Dr. Sanders: [092-01:08] Thank you very much. Any questions? Dr. Rubin.

Dr. Rubin: [109-01:09] We've spent two days here... I'm still thinking about the Reverend in the back there but we spent two days here. I think one of the things you find out when you come down and do a program here for a couple of days is just how... you know, I've seen this before when I've visited Texas, just how many community people there are here in Texas to take care of your families and your children. Whether it's the church, whether it's a Compadre to Compadre program or domestic violence program, etcetera. The fundamental challenge that we have and I guess to me if you're talking about fences, intergenerational mental health issues, you touched on the children, but the mental health of these parents and the preparedness of these parents just like the police chief talked about politics aside around Medicaid expansion or not or whether the resources, the challenge we have is only so much can go in the federal law. This is a state and federal involvement. How does the community come together with all these organic resources and really develop a vision around treating adverse child experiences from an intergenerational perspective? Because that to me is closer to the fences that the Reverend was talking about. The struggles that a community has in sort of working around the politics that can occur between states and federal government, etcetera, those types of things.

Castro: [109-03:26] I appreciate your question. My training is I'm a licensed marriage and family therapist and a licensed professional counselor. Prior to working where I'm at today I worked for a community mental health, substance abuse provider as director of children's operations. One of the components that I believe worked best and was most helpful and supported families and then touched on mental illnesses within families are those home-based services. Now the challenge is, and if I'm in your shoes, is how do you take it to scale? That's the biggy. We've got to be able to take it to scale. And that's where I believe organizations like mine have the ability to assist

and partner with child protective services to take it to scale. Child protective services, for the noble work that they do, often get set up as being traffic cops. They're the ones directing where the families go and what they do. But it's the organizations like us who get inside the home, develop the relationships with the child and the family and have the ability to get them to the mental health services they need or more likely, we provide them ourselves. How are we able to do that? We know there's not enough funding in all the world currently, so through our ability, through our philanthropy donors, that's how we supplement the care that we provide, and I believe that there's a tighter partnership kind of like Samson. I love the Samson model and how they do their systems of care process. I believe if organizations like us could apply directly to flexible funding, title IV-E or other funders, for child welfare that would see more innovation and would see more success in treating these families.

Dr. Sanders: [110-00:12] Thank you very much Mr. Castro. Our last presenter is Melissa Stoeltje who is a social services reporter for the *San Antonio Express-News*.

Melissa Stoeltje: [110-04:55] Thank you so much for inviting me to speak today. I've covered social services for the last several years, CPS included. I want to start out by saying I have the utmost respect for CPS workers from the rank and file all the way up to Commissioner Specia. They have an incredibly challenging job and often thankless job, and I respect the hard work they do. That being said I'm here to talk about some of the problems I have with covering CPS in my beat. The biggest problem I struggle with as a reporter concerns the agency's confidentiality policies. When a child dies of suspected abuse and neglect, the only material that CPS is required to release is a child fatality report or a 2059. These documents contain cursory and very superficial summaries of the child's death, including any prior involvement the family has had with CPS. The summaries contain some basic information such as the date of prior CPS involvement and disposition of the investigation. These summaries are bare bones and don't give a true in-depth reflection of the family's dealings with the agency and most important CPS actions in these cases. What's more, when a child dies the 2059 is bare bone as it isn't usually available for a period of time, often weeks. Therefore as a reporter, I must rely on whatever the CPS public relations official decides to tell me about the child's death, including any prior CPS involvement with the family, the nature of that involvement and the issues going on in the family.

I focus on prior CPS involvement because Bexar County routinely leads the state in having the highest number of children who are victimized, again fatality or not, within five years of their families receiving services through CPS. So you may ask, why is it so important for me as a reporter to have in-depth background on CPS dealings with families that come into the system. Let me give you an example. Last year I wrote a story about an 8-year-old girl who died of untreated appendicitis. Doctors said she would have lived if she received timely medical treatment. In the two years before her death, her parents were repeatedly investigated by CPS over allegations of neglect. At one point, a caseworker validated the parents for neglect, but that finding was overturned by management after the couple made a lot of noise, lawyered up and asked for administrative review. The reasons given for the reversal included the fact that the worker had lost her federal documentation.

That decision seemed to set the tone for how CPS interacted with the family going forward. Time and again, CPS failed to act when the parents refused to take part in

prescribed family services or comply with other elements of the agency's plan to reduce risk in the home. In the 48 hours before the girl died, three different people, a school counselor, a school nurse, and a police officer contacted CPS saying they were worried the girl was in danger. But a CPS manager failed to send anyone to conduct even a basic welfare check on Sara, deciding that the family services worker, who hadn't visited the family for at least six weeks and perhaps as long as nine weeks, could handle any concerns in the home on her next home visit. Sara died alone in her vomit-encrusted bed.

After her death, CPS, at the request of an enraged State Senator Carlos Uresti, conducted an internal review. The result was a toothless recommendation that reiterated the need for employees to understand policy. No one at the agency seemed to be held accountable for key decisions in the case. Because I was able to get access to almost all of the records through a source, including the contact logs and narratives and impact the CPS computer system, I was able to tell the whole story of CPS's involvement in this tragic case. As a result of that story and another that followed, the Office of Inspector General has opened its own investigation into CPS actions in Sara's case. The results are pending.

Whether that investigation will result in any true accountability or policy change in the agency remains to be seen. I understand the confidentiality policies are in theory designed to protect the privacy of children and families. But from my perspective in practice, what they end up protecting is CPS, in that they shield the agency from any true public oversight. From my perspective as a journalist, it would seem confidentiality statutes serve to allow CPS to police itself. It is my belief that when a child dies or is seriously injured from suspected abuse or neglect all CPS documents on that family should be immediately released to both the media with redactions if need be. So that we may write full and true accounting on what went wrong and how the agency can better do its job. After all the lives of precious children are at stake. Thank you.

Dr. Horn: [110-04:56] Unfortunately, somebody has to go last and it's really unfortunate it was you because I could spend a half hour talking to you about this. As Mr. Chairman when we talk about confidentiality, we get reporters' viewpoints on this. Because it's really important because I've seen in other areas where media have been instrumental in highlighting issues, which have led to things like increased funding and more public will, commitment to do something on a problem. But I was struck this morning, I don't know if you were here when Judge McCown was here. He said, and it strikes me as very true, having worked in child welfare pretty much all of my life, which is when media reports these things, the result is not the public saying we need to do something to spend more, it's whose head should roll. I will tell you that I was offered an administrative to be a head of a state child welfare agency and I turned it down because it is the graveyard. Sorry Judge Specia. It is the graveyard of promising careers. When I'm old and gray maybe I'll do something like that. I sure wasn't going to do it at 38 [laughs]. Because of this and very briefly but I would really like to explore this more in a later, help us understand how rather than the stories resulting in somebody losing their job, how can these stories be written in a way that creates a will to do something that is much more proactive?

Stoeltje: [111-01:44] That's the \$10,000 question.

Dr. Sanders: [111-01:46] Before you start, this will be a major topic of our next meeting, so we'll have this to whet our appetite going into that and then we'll close out comments.

Petit: [111-01:58] Can I just add we just got \$100 million increase in the budget and 1,000 new employees, that when Judge Scott McCown issued a report 10 years ago called "Stuff for the Children," it resulted in a \$300 million report, so there may have been some heads that had rolled in some of these things that's part of what goes with these. These revelations won hundreds of millions of dollars in this very well --

Dr. Sanders: [111-02:19] We'll have plenty of time to discuss this next month. Go ahead.

Stoeltje: [111-02:21] That's a very complicated question and all I can do is speak as a reporter is when I write my stories it's not that we want heads to roll, we want legislatures and people that matter to read our stories and for it to effect thorough change not just to get people fired because that's just a temporary fix. So often what happens is the child dies and there's a big media outpouring, readers get outraged and there's a few letters to the editor and then time goes on and the next death happens. So my goal is to write stories that will effect thorough change and not be punitive to the people that are overworked, not paid enough, I totally understand that. So I would appreciate any feedback on how we can do our job that would achieve that.

Dr. Sanders: [111-03:03] Thank you and we'll plan to keep you involved in this process. Thank you very much. So we are at the time of adjournment of our meeting and I just want to thank the presenters certainly those today and yesterday and particularly for all of the presenters who had to operate within time constraints and came to their states and demanded a lot of them and they took time and really appreciate your dedication and comments. I also want to thank those who came, who didn't speak but listened, including those on the phone and in the audience. Thank the media for coverage. The Commission has received quite a bit of coverage yesterday and I'm sure it will today, and I think that the idea of having a public dialogue has been an important component of the Commission and so we've seen that. Thanks to Congressman Doggett and his staff, who really arranged the location as well as connected us to many of the speakers, and thanks to the Commission staff for putting on such an outstanding two days for us and a lot of information that we gathered. Our next meeting will be in Tampa on July 10, and as we heard today we'll have much of a focus on confidentiality. We will have a call in the middle of June to do more planning for that meeting, and any last comments from Commissioners?

Group: [111-04:25] Thank you.

Dr. Sanders: [111-04:30] So we'll adjourn. Thank you very much. Have a safe trip home.