

WHAT DO WE COUNT? WHAT SHOULD WE COUNT AND WHY DOES IT MATTER?

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What do we count?

DEATHS DUE TO CHILD MALTREATMENT

1. What is a death due to child maltreatment?
2. Who decides if the death is due to child maltreatment?

What is a death due to child maltreatment?

IT DEPENDS ON WHERE YOU LIVE

CAPTA → Any recent act or failure to act on the part of a parent or caretaker, which results in death.....

Georgia → Physical injury or death inflicted upon a child by a parent or caregiver by other than accidental means.

Ohio → When a child “exhibits evidence of any physical or mental injury or death, inflicted by other than accidental means, that is at variance with the history given of it.”

Oklahoma → “Heinous and shocking neglect” includes “An act or failure to act by a parent that results in the death or near death of a child”

Who decides if the death is due to child maltreatment?

IT DEPENDS ON WHERE YOU LIVE

Alaska → “...only if the Medical Examiner’s Office concludes that the fatality was due to maltreatment.”

New Jersey → Only if the “DYFS Director makes a determination as to whether the child fatality was a result of child maltreatment.”

Wisconsin → Only if the “children who were subjects of reports of abuse or neglect in which the maltreatment allegation was substantiated. No agency other than the state DCF is used to compile child maltreatment fatality information.”

How sure do you need to be to call it a death due to maltreatment?

IT DEPENDS ON WHERE YOU LIVE

States use different evidentiary standards to determine a child has been maltreated

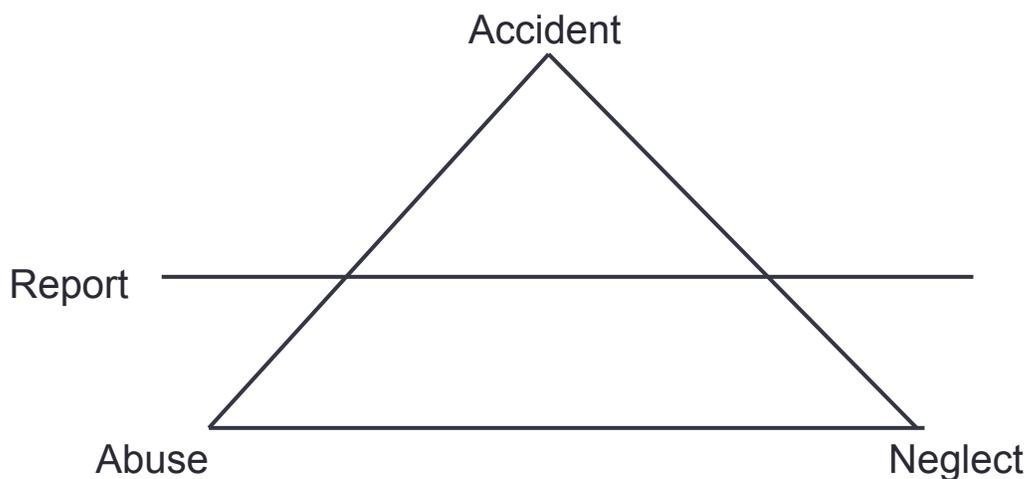
The majority of states (36) utilize a “preponderance standard” while other use terms such as “credible evidence”, “reasonable evidence” and “substantial evidence.”

Kansas is the only state which uses a “clear and convincing” standard

AND POTENTIALLY OVER TIME IN THE SAME PLACE....Pennsylvania used a clear and convincing standard for several years due to a state supreme court decision – the General Assembly recently affirmed a return to “substantial evidence”

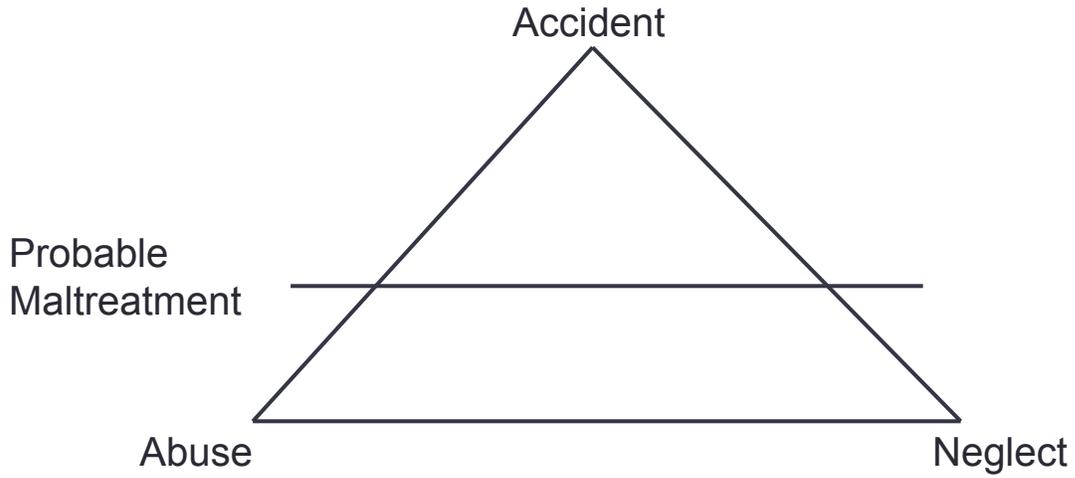
All of these levels are intentionally lower than the “beyond a reasonable doubt” standard in criminal proceedings

LEVENTHAL’S TRIANGLE

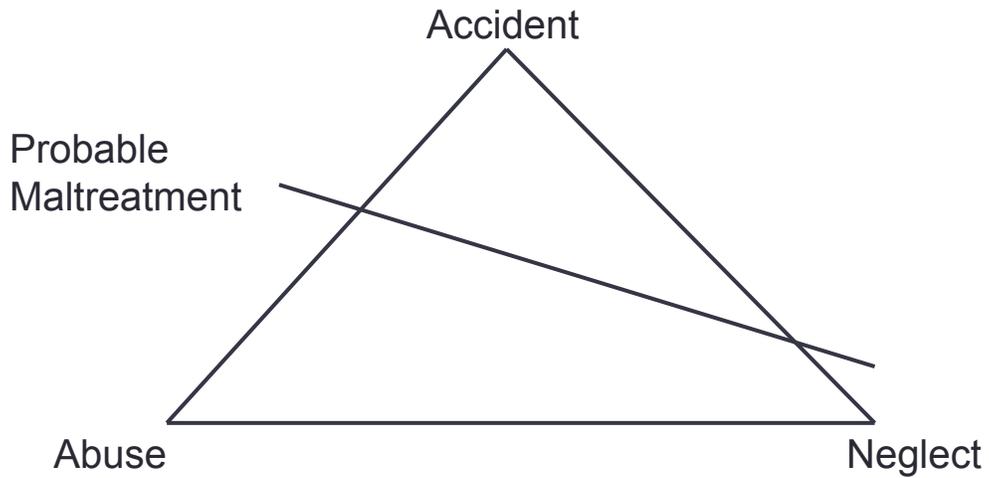


Asnes & Leventhal. Pediatr Rev. 2010;31(2):47-55

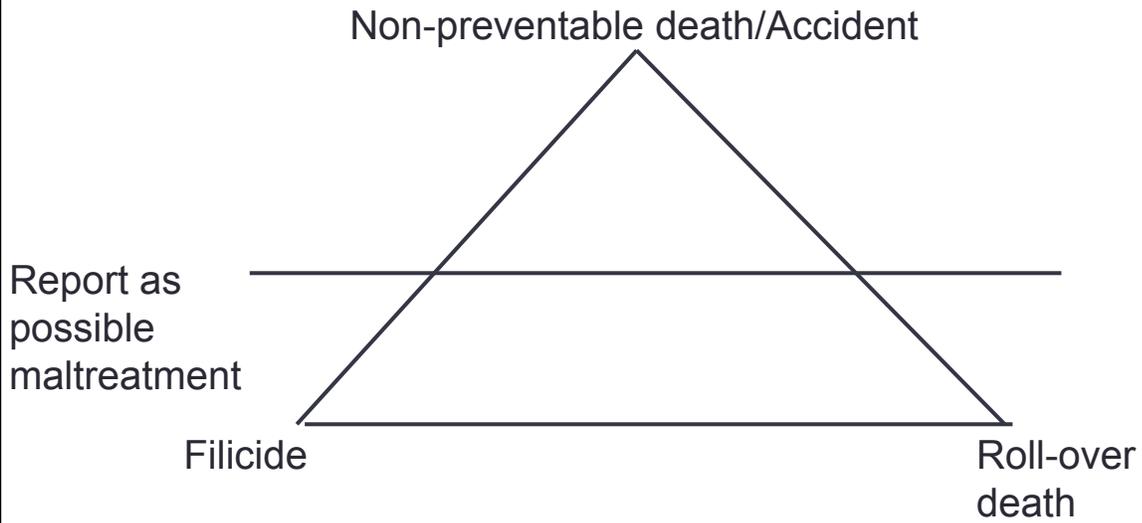
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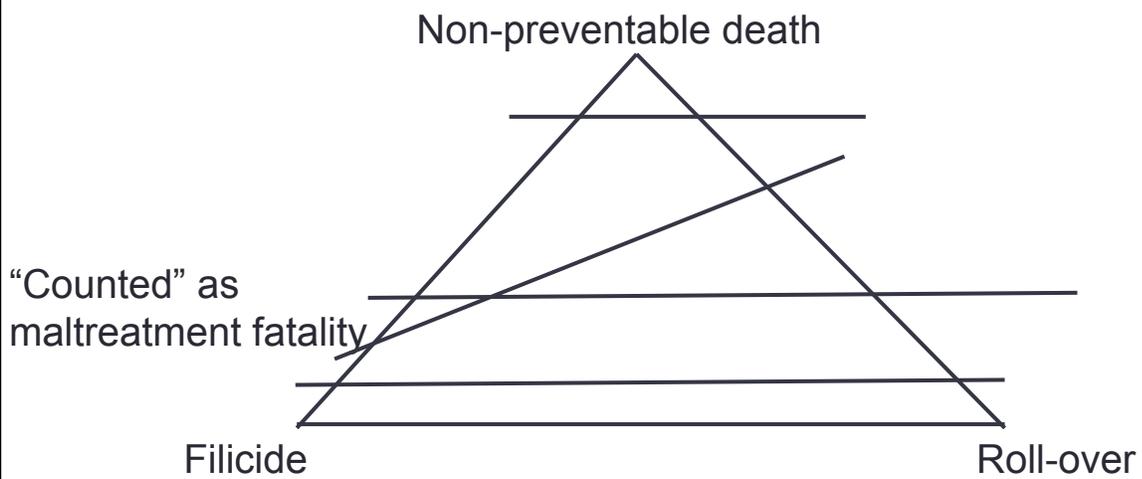
LEVENTHAL'S TRIANGLE



LEVENTHAL'S TRIANGLE FOR CHILD FATALITIES



LEVENTHAL'S TRIANGLE FOR CHILD FATALITIES



Filicide: The deliberate act of a parent killing his/her child

Mother who drowns her child

Father who shoots his children

Although we likely all agree these should be “counted” as deaths due to maltreatment, these may be the LEAST preventable by Child Protective Services and/or any other evidence-based interventions

What is a death due to physical abuse?

A death due to

- Abusive head trauma
- Abusive abdominal trauma
- Burns
- Battering

Should children who die from these injuries always be “counted” as deaths due to child maltreatment?

What is a death due to child physical abuse?

Are there situations in which they should not be “counted”?

- What if the perpetrator is very remorseful and did not intend to kill the child?
- What if CPS has had no prior contact with the child or family?
- What if there are no living siblings?
- What if the medical expert states that it is unequivocally abuse but the coroner says the manner of death is undetermined?
- What if the police prosecute and the caretaker is convicted, but CPS does not indicate the case?

What is a death due to supervisory neglect?

IT DEPENDS ON WHERE YOU LIVE

Kentucky → “Engages in a *pattern of conduct* that renders the parent incapable of caring for the immediate and ongoing needs of the child, including, but not limited to, parental incapacity due to alcohol and other drug abuse.”

Pennsylvania → Newly enacted legislation – “A *repeated, prolonged or unconscionable egregious failure* to supervise a child in a manner that is appropriate considering the child’s developmental age and abilities.”

Minnesota → “Failure to provide necessary and appropriate supervision or child care arrangements for a child *after considering such factors as the child’s age, mental ability, physical condition, length of absence, or environment*, when the child is unable to care for his or her own basic needs or safety, or the basic needs or safety of another child in their care.”

Texas → “Placing a child in or failing to remove a child from a situation in which a *reasonable person* would realize requires judgment or actions *beyond the child’s level of maturity, physical condition, or mental abilities* and that results in bodily injury or a substantial risk or immediate harm to the child.”

What types of deaths can be due to supervisory neglect?

- Fire-related death
- Drowning
- Gun-related death
- Drug ingestions
- Falls (e.g. out windows)
- Exposure to heat/cold

Deaths due to supervisory neglect

Questions which are often discussed:

How long is too long to leave children alone?

What if the parent is impaired by drugs or alcohol when the death occurs?

Does it matter how long the parent left the infant (5 minutes vs. 15 minutes)?

Do patterns matter? What if CPS has been involved multiple times for similar concerns such as inappropriate supervision?

For drug ingestions, does it matter if the drug is legal or illegal? What if it was legally prescribed to a caretaker? Does it matter if it took a lot or a little drug to kill the child?

Are there certain scenarios which are neglect regardless of other circumstances
- leaving a 6 mo old in a bathtub? Leaving a child with access to a loaded gun ?

Gun deaths – Variation in classification

2011 **unsubstantiated** case

3-year old found a gun and shot himself

Law enforcement “found bullets in the closet and one piece of crack cocaine floating in the toilet, along with numerous items of drug paraphernalia. House in total disarray.

Not substantiated because the CPS investigation “did not reveal substantial evidence of serious physical injury as a result of lack of supervision” on the part of the mother.

Criminal charges were filed a person who was not considered a ‘perpetrator’ under state law.

2011 **substantiated** case

4-year old found a gun and shot himself

The child found a loaded gun lying on a table and shot himself in the head.

Family not known to CPS previously.

No drugs or alcohol involved.

Gun deaths – Variation in classification

2012 **unsubstantiated case**

19-month-old suffered a “fatal gunshot wound to his head” as his mother “was attempting to unload a handgun she intended to sell to a former drug dealer.”

The family was the subject of a report to CPS less than a week before the fatality related to concerns that mom “was using drugs heavily; that she was taking the victim child with her to buy drugs and did not have diapers for the child.”

Unsubstantiated because mother didn’t intend for a bullet to come out of the gun

Of note, a previous child was removed from her and adopted due to mother’s drug addiction

Drowning deaths - Variation in classification

2013 substantiated case

1-year old child died when mother left the child in the bathtub with his two siblings (ages 1 and 3) for 5-10 minutes. The mother stated that she was relying on the 3 year old to let her know if anything was wrong. The father was upstairs in another room playing video games. When the mother came back upstairs, the child was under water.

2010 unsubstantiated case

3-year-old died in a family pool. Family members reported that the child had on a life vest prior to being found in the pool. When the child was found face down in the pool, she was no longer wearing the vest. There was an 8-10 minute period during which adults were not aware of child's location.

Unsubstantiated because "that the child was in a blind spot from where her mother and aunt were."

During the investigation, CPS learned that when the child was 2-yr old and living in a neighboring county, the child had been "found walking ¾ mile to a community pool alone. This incident was reported to have occurred three days in a row prior to police involvement." CPS had no record of a referral.

What is a death due to medical neglect?

IT DEPENDS ON WHERE YOU LIVE, BUT PROBABLY LESS SO THAN IN OTHER TYPE OF MALTREATMENT

Medical neglect usually takes 1 of 2 forms

1. failure to heed obvious signs of serious illness
2. failure to follow a physician's instructions once medical advice has been sought.

Several factors are considered necessary for the diagnosis of medical neglect

- a child is harmed or is at risk of harm because of lack of health care;
- the recommended health care offers significant net benefit to the child;
- the anticipated benefit of the treatment is significantly greater than its morbidity, so that reasonable caregivers would choose treatment over non-treatment;
- it can be demonstrated that access to health care is available and not used; and
- the caregiver understands the medical advice

What is a death due to medical neglect?

- What if the family has a religious belief that impacts their medical decision making?
- What if there is family chaos and disorganization?
- What if there is lack of trust in physicians or other health care professionals due to previous experiences?
- What if there is cognitive impairment of caregivers?

AND THEN THERE ARE DEATHS RELATED TO UNSAFE SLEEP

Cultural norms as it relates to preventable deaths

- When babies died during sleep, we used to call it SIDS
- Researchers studying SIDS noted that most of these infants were sleeping on their stomachs, with pillows and bumpers in their cribs
- In 1992, the AAP recommended that babies sleep on their backs or sides to reduce the risk of SIDS – the statement that was revised in 1996 to only recommend back sleeping
- In 1994, NICHD launched the "Back to Sleep" campaign

Cultural norms as it related to preventable deaths

- Incidence of 'SIDS' has dropped more than 50%
- People have started to question whether there is SIDS without risk
- The vast majority of cases which we used to call SIDS were likely unsafe sleep and are preventable with simple measures
- When is putting your baby on his/her belly to sleep considered a type of neglect?
- Should deaths due to unsafe sleep be "counted"?

Cultural norms as it relates to preventable deaths

3-month-old infant died as a result of an “avoidable tragedy” after the child’s mother had been “co-sleeping with her children.” The mother had seven children and had been “educated in the dangers of co-sleeping,” including from her pediatrician. The case was indicated as neglect by CPS.

“For 2009 and 2010 reviews, a larger percentage of the deaths attributed to neglect were in infants than in the previous two years. This finding is due in large part to local review teams increasingly identifying sleep-related infant deaths as neglect.” (Maura D. Corrigan, Director Michigan Department of Human Services, 2012)

Why does all of this matter?

- **We want to prevent deaths due to abuse and neglect**
- In order to develop evidence-based interventions which can help prevent these deaths, we **MUST** have high-quality, consistent data about **ALL** of these deaths
- We need to know how many children died and why they died in order to prevent other children from dying and to measure the effectiveness of prevention efforts.
- With non-random sampling of cases, there will be bias. This will hinder our ability to understand the true risks to children and develop successful evidence-based prevention programs

If we only “count” cases in which there was prior CPS involvement, for example, this creates a biased sample of deceased children. Children who are killed **DESPITE** CPS services are potentially a **VERY** different group than children who are killed who never received CPS services.

What type of system will allow us to do this?

- The system we use to count deaths and collect data about the circumstances surrounding the deaths needs to be set up for the benefit of CHILDREN
- IT NEEDS TO BE A CHILD-CENTRIC SYSTEM
 - It cannot be for the benefit of the parents - many times cases aren't indicated because the death of the child is "punishment" enough - tendency to label neglect cases "tragedies"
 - It cannot be because investigators are overcome 'there by the grace of God go I' frame of thought - especially in neglect cases
 - It cannot be because various systems are afraid of being blamed for their actions/lack of actions or are trying to meet certain requirements to continue to get support - requirement to report whether family preservation had been in the home

Think about the current counting

- Supplying data to NCANDS is voluntary
- CAPTA does not require interdisciplinary reviews
- There is tremendous variability in what is "counted"
 - Some states don't "count" cases if the family was not previously known to CPS
 - Some states don't "count" cases if there are no siblings
 - Some localities don't "count" cases if the perpetrator kills himself after the abuse occurred
 - Some states have a narrow definition of who can be a perpetrator – if the child is killed by a non-perpetrators, it doesn't "count"

Pennsylvania has never counted cases in which the perpetrator is unknown

THIS IS NOT CHILD-CENTRIC WAY TO COUNT CHILD DEATHS AND IT DOESN'T REFLECT HOW IMPORTANT WE BELIEVE THIS PROBLEM IS

So how do we develop a child-centric way to count deaths?

- Begin a conversation about why it is important to “count” every potentially preventable child death
- Begin to develop consensus at the federal level about what “must be counted”

CDC definition of AHT

- Routine surveillance of the rate of AHT has been limited by the lack of standard case definitions
- In March 2008, an expert panel was convened to develop code-based case definitions for AHT
- The panel reached consensus on 2 definitions
 - **A broad operational definition - emphasizes sensitivity of case ascertainment and recommended for general population-based surveillance**
 - **A narrow operational definition - emphasizes specificity and recommended for more focused assessments**

Could we do something similar for child maltreatment fatalities?

- Could we convene an expert panel to agree on broad and narrow definitions of a death due to child maltreatment?
 - The 'narrow definition' might include all filicide, most physical abuse cases, possibly cases in which all member of the child death review team are in agreement
 - The 'broad definition' might include roll-over deaths, certain drowning deaths in which there is not consensus from the child death review team

Whether CPS substantiates a case may not be the critical point
IN FACT, THE COUNTING MAY NEED TO OCCUR INDEPENDENTLY OF
THE CPS SYSTEM

What about near-fatalities?

Near-fatalities and prevention

- Counting near fatalities may be particularly important when assessing prevention programs
 - Rates of death are LOW – which is good for children but bad from a research perspective
 - Children with near-fatalities likely have many of the same risk/safety factors as children who die
 - The difference between fatality and near-fatality is often LUCK and not a difference in the safety risk
- GAO as one of 4 recommendations recognized importance of near fatality –
 “Estimate the costs and benefits of collecting national data on near fatalities...”

What is a near-fatality?

IT DEPENDS ON WHERE YOU LIVE

CAPTA - “An act that, as certified by a physician, places the child in serious or critical condition.”

Colorado → A case in which a physician determines that a child is in serious, critical, or life threatening condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment.

California → A severe childhood injury or condition caused by abuse or neglect which results in the child receiving critical care for at least 24 hours following the child's admission to a critical care unit

Pennsylvania → A child's serious or critical condition, as certified by a physician, where that child is a subject of the report of child abuse

Conclusions

- We currently do not have consistent definitions for what a death due to child maltreatment is
- As a result, every state and even different regions within a given state count deaths from maltreatment differently
- The reason for the lack of consensus is understandable
 - The circumstances surrounding a child death are often very complicated - every case is different
 - There are cultural norms which can change over time and may differ by region and/or state
 - The 'obvious' cases such as filicide are the exception, not the rule
 - There are many systems at play with different incentives, disincentives, legal mandates etc.

BUT in order to improve our ability to develop evidence-based interventions to prevent child abuse fatalities, it is critical that we have a child-centric system of counting death due to child maltreatment

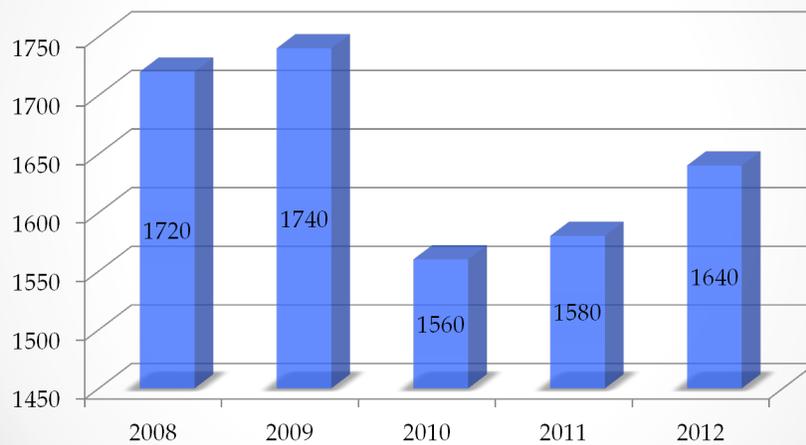
THANK YOU

Measurement of Fatal Child Maltreatment

Sam P. Gulino, MD
Chief Medical Examiner
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National estimate of FCM

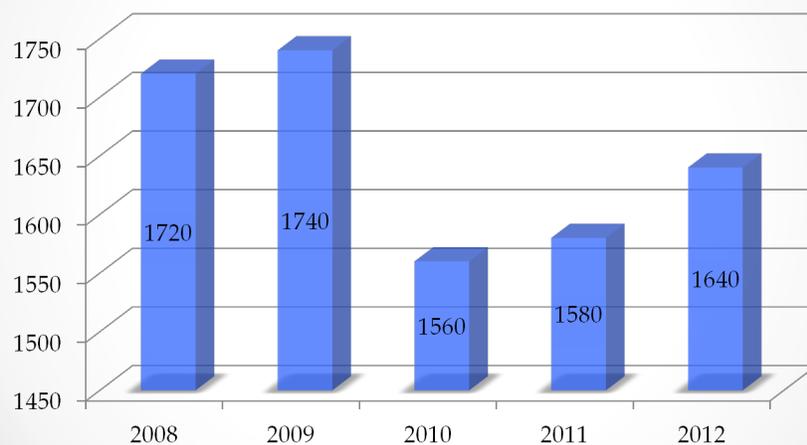


Source: HHS, ACYF, Child Maltreatment 2012

National estimate of FCM

- Source is the National Child Abuse and Neglect Data System (NCANDS)
 - Receives reports on CAN from 50 states + DC + PR
 - Reporting is voluntary
 - Historically, half the reporting states base the count solely on child welfare data
 - A state may report individual cases or may report an annual estimate of the number child maltreatment fatalities
 - When < 52 states report, the "count" for the reporting states is used to generate an estimate for the non-reporting states based on population

National estimate of FCM



Source: HHS, ACYF, Child Maltreatment 2012

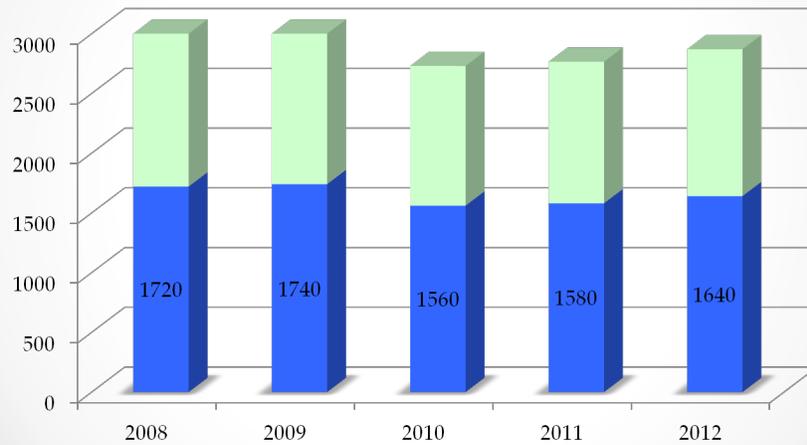
Why worry about measurement?

- Public health surveillance depends on:
 - Defining (the thing to be measured and the population)
 - Collecting data
 - Analyzing and interpreting the data to:
 - Plan
 - Implement
 - Evaluate
- ...public health practice intended to achieve a particular outcome

How badly are we undercounting?

- We don't know.
- Schnitzer et al 2008
 - Child welfare data undercounts FCM by 55-76%
 - Michigan
 - Child fatality review with special emphasis on identifying deaths due to child neglect
 - 75% increase in fatalities classified as child maltreatment over a 2-year period

National estimate of FCM



Data Sources in FCM

- Child welfare data (NCANDS)
- Death certificate data
- FBI Uniform Crime Reports data on homicides
- Child fatality review data

Child welfare data

State	% FCM cases missed
California	76%
Michigan	56%
Missouri	21%
Rhode Island	73%

*Sources:
Ewigman et al. 1993
Schnitzer et al. 2008*

Child welfare data

- May only capture cases in which the child or family have a child welfare history prior to the occurrence of the fatality
- Of those that capture fatalities regardless of child welfare history, some only classify a death as CM if a perpetrator is identified
- Undercount of neglect-related fatalities

Death certificate data

State	% FCM cases missed
California	80%
Colorado	50%
Michigan	90%
Missouri	52%
Rhode Island	83%

Sources:

Crume et al. 2002

Ewigman et al. 1993

Schnitzer et al. 2008

Death certificate data

- Inconsistent qualifications and training of those investigating and certifying CM deaths
- Lack of standards in death certification
- Errors in ICD coding

FBI-UCR homicide data

State	% FCM cases missed
California	44%
Michigan	56%
Missouri	82%
Rhode Island	85%

*Sources:
Ewigman et al. 1993
Schnitzer et al. 2008*

FBI-UCR homicide data

- Not all states require reporting of data
- Many neglect-related deaths do not lead to criminal charges

Child death review data

State	% FCM cases missed
California	45%
Michigan	68%
Rhode Island	2%

Source: Schnitzer et al. 2008

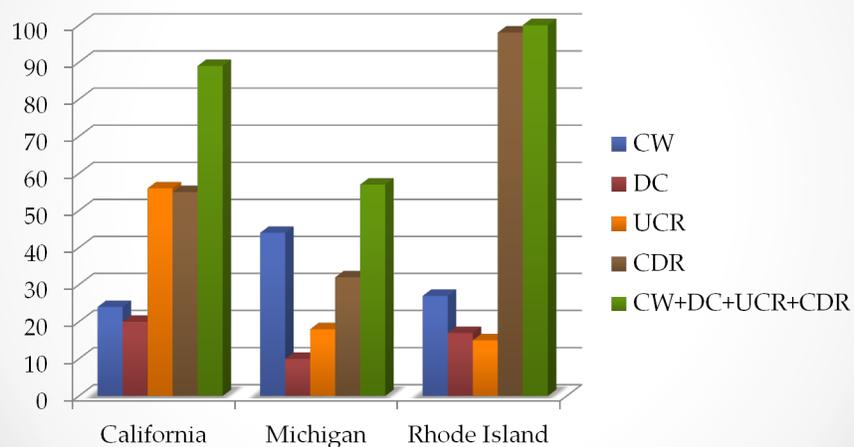
Child death review data

- 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 and knowledge about FCM
- Child maltreatment definitions not applied consistently

Data Sources in FCM

- Child welfare data (NCANDS)
 - Death certificate data
 - FBI Uniform Crime Reports data on homicides
 - Child fatality review data
-
- No one data source has proven adequate
 - Case ascertainment is enhanced when multiple sources are used

Data Sources in FCM

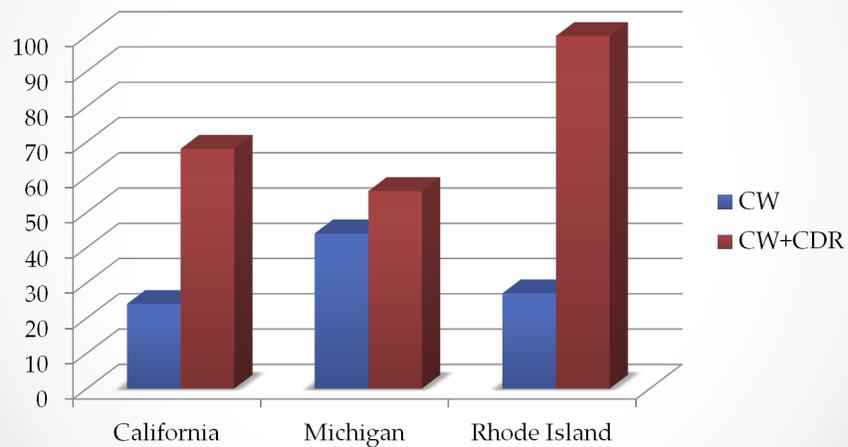


Source: Schnitzer et al. 2008

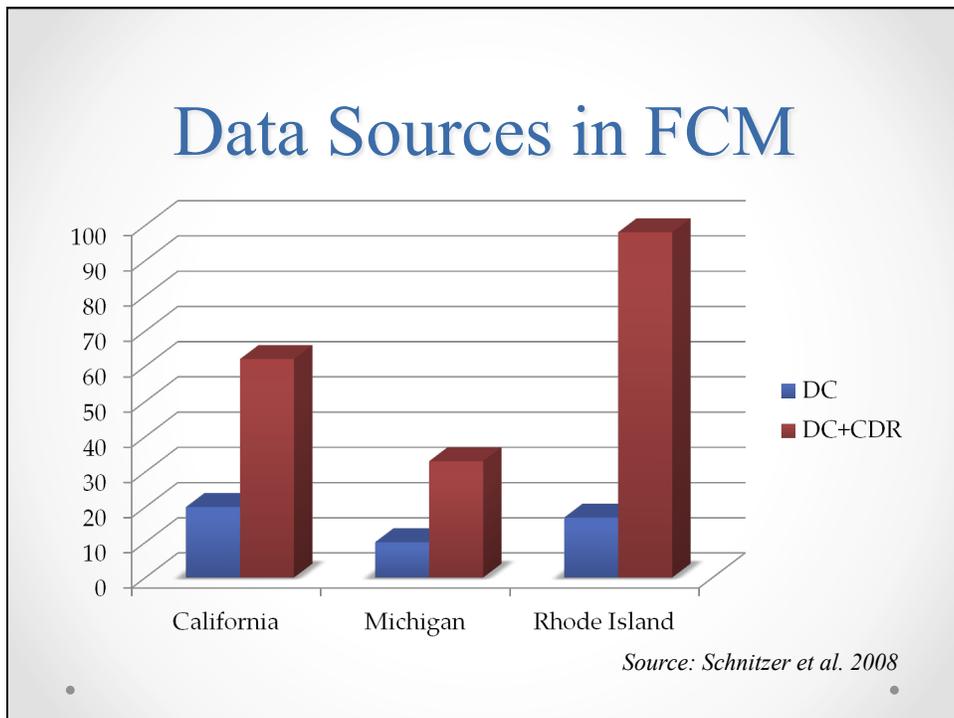
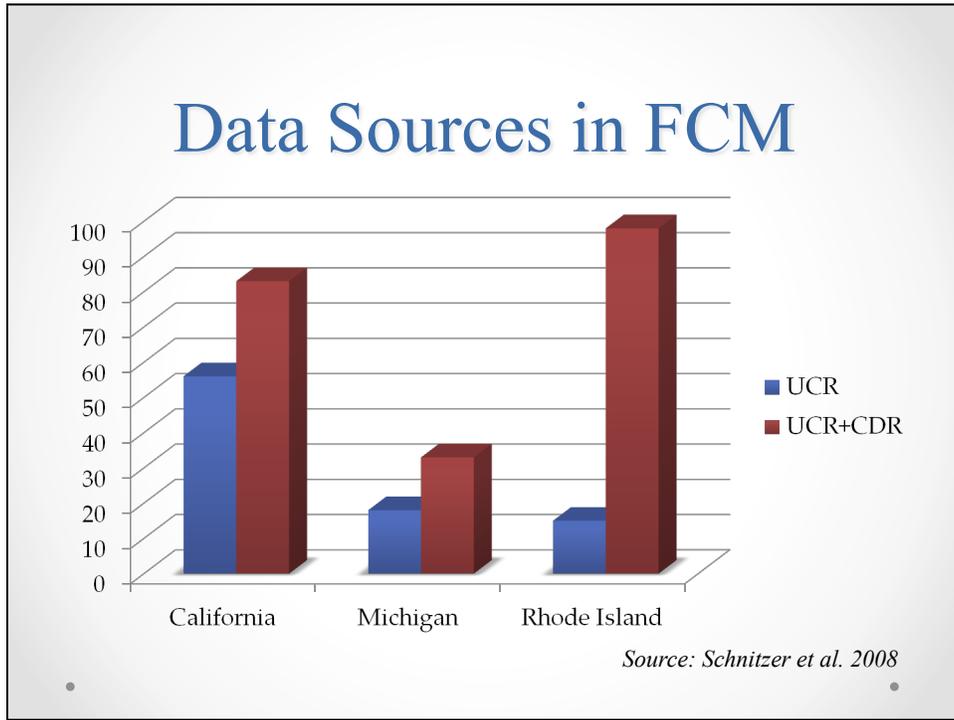
CFSIIA of 2011

- Child and Family Services Improvement and Innovation Act of 2011
- Requires states to:
 - Describe the various sources of data used in coming to their count of child fatalities
 - Explain, if applicable, why data from other sources (death certificates, CDR, law enforcement, MEO/Coroner) was not used

Data Sources in FCM



Source: Schnitzer et al. 2008



Schnitzer - NCHS

- Matching CDR and DC data
 - 9 states
 - Children 1 week through 4 years old
 - Deaths occurring in 2009 or 2010
- Developing a method for better identifying child maltreatment deaths from NCHS data

Child death review

- Using CDR as the mechanism for improving the national count of FCM is an attractive option because:
 - CDR has been shown to improve ascertainment of FCM when coupled with at least one other data source
 - Each state (and Washington DC) has a CDR process in place
 - CDR teams often include people with expertise in child maltreatment

FCM definitions

- Physical abuse
- Neglect

FCM definitions

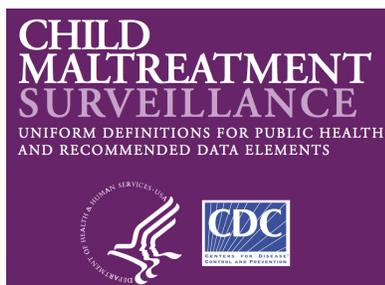
- Physical abuse
- Neglect
- Physical abuse tends to be the less problematic of the two
 - Most agencies and professions agree on the types of acts that constitute physical abuse
 - Still can be disagreements based on agency-specific criteria

FCM definitions

- Physical abuse
- Neglect
- Agency-specific definitions
 - Religious exemptions
- Making distinctions between neglect and Neglect
 - Each agency and investigator may have differing views of societal norms regarding acceptable parenting practices

FCM definitions

- Need for definitions that:
 - Are not linked to, or trumped by, any one agency's or profession's definitions
 - Can be understood and applied by CDR team members



Inadequate supervision

- “Failure by the caregiver to ensure that the child engages in safe activities, uses appropriate safety devices, is not exposed to unnecessary hazards, or is supervised by an adequate substitute caregiver.”
- Does not solve the problem of inter-agency and inter-observer variation

AF-FAP diagnostic system

- Slep and Heyman, 2006 and 2009
- Partnered with Air Force Family Advocacy Program to develop and validate specific, operationalized substantiation definitions
- Breaks the decision down into simpler component decisions about the presence or absence of specific conditions, behaviors, and outcomes
- Compared determinations of Community Maltreatment Decision Boards and Master Reviewers

AF-FAP diagnostic system

	% agreement	κ
Physical abuse	91	0.82
Neglect	84	0.66
Emotional abuse	90	0.73
Sexual abuse	95	0.89
All CM	88	0.75

Source: Heyman and Slep. 2009

Improving FCM counts

- Use multiple data sources to identify potential cases of FCM
- Improve existing CDR infrastructure so that it can be used to evaluate, categorize, and count cases of FCM
 - Create agency-independent definitions of FCM that can be applied universally
 - Use of a Heyman-Slep-like tool to improve agreement among teams

Death certificates

- Designed to standardize completion and recording across states
 - Standard national form
 - Technical assistance
- Death certificates are required to be filed for every death
 - Compliance rate is high
 - Incompleteness is a problem, but completion rates are high for the two sections that are necessary to properly code maltreatment deaths
 - Cause of death
 - How injury occurred
 - ICD codes: T74, Y06, Y07

Death certificates

- Natural deaths
 - Clinical physicians
- Violent or suspicious deaths
 - Medical examiners and coroners
- Use of DC data to count cases of FCM relies on:
 - Proper investigation
 - Proper certification

Medical examiners and Coroners

- Medical examiners = medical doctors trained in forensic pathology
- Coroners = elected officials who need have no prior training in medicine, forensic science, or death investigation
- Regional variation
 - Louisiana – coroners are elected must be physicians unless no physician is available
 - Kansas – coroners are appointed physicians

Death investigation systems

- Established by state law
 - Statewide medical examiner
 - Regional or county medical examiners
 - County coroners
 - Mixed coroners and medical examiners
- About 70% of death investigation offices in the US are coroner's offices*

**Source: National Research Council. 2009*

Coroner education

- Some states require coroners to receive basic education, either prior to taking office or as continuing education
- Inconsistent requirements across states
- Comprehensive training around child death investigation not universally required
- Even when coroners seek training in child death investigation, it is theoretical and not reinforced by practical experience

Coroners and autopsies

- In jurisdictions with coroners, the coroner typically has sole discretion in determining if an autopsy will be done, and by whom
- Forensic pathologists may not be available or too costly
- Autopsies often done by hospital pathologists without forensic expertise

Coroners and autopsies

- In those situations where a coroner does engage a forensic pathologist to perform the autopsy, he is not bound by the forensic pathologist's opinion
- Indiana State Coroners Training Board, 1996
 - Coroners "may record a manner of death that is independent, and different, from that of the pathologist. However, any disagreement between a pathologist's and coroner's determination of the manner of death should be based on material fact and data not available to the pathologist."

Medicolegal death investigation

- Autopsy must be performed with full knowledge of the circumstances surrounding death
 - Interpret autopsy findings in context
 - Gather information to answer questions central to the investigation
- Clinical diagnosis is done with knowledge of:
 - Medical history
 - Physical examination
 - X-rays
 - Laboratory tests

Lack of DC standardization

- Lack of ICD coding as child maltreatment due to:
 - Poor wording of cause of death
 - Poor wording (or absence) of how injury occurred
- Proper death certification is barely taught in US medical schools, much less to lay coroners
- Choice of language sometimes informed by subjective, emotional, or even political considerations

Lack of DC standardization

- Cause of death – *Hemophilus influenzae* pneumonia
- Manner of death – Natural
- How injury occurred – (left blank)

Lack of DC standardization

- Cause of death – *Hemophilus influenzae* pneumonia
- Manner of death – Natural
- How injury occurred – (left blank)

- Cause of death – *Hemophilus influenzae* pneumonia
- Manner of death – Homicide
- How injury occurred – Caretakers failed to get medical care for child

Lack of DC standardization

- Cause of death – Drowning
- How injury occurred – Drowned in swimming pool

Lack of DC standardization

- Cause of death – Drowning
- How injury occurred – Drowned in swimming pool

- Cause of death – Drowning
- How injury occurred – Unattended child fell into home pool lacking perimeter fencing

Lack of DC standardization

- Cause of death – Drowning
- How injury occurred – Drowned in swimming pool
- **Manner of death – Accident**

- Cause of death – Drowning
- How injury occurred – Unattended child fell into home pool lacking perimeter fencing
- **Manner of death – Accident**

Long-term solution

- Transition coroner systems to medical examiner systems
- Regulate death investigation by promulgating standards of practice for forensic pathologists and medicolegal death investigators

Long-term solution

- Slow and difficult process
 - Creation of model statute
 - Adoption by states
 - Expansion of pathology training programs
 - Increase funding for medical examiner facilities, equipment, staff, and training

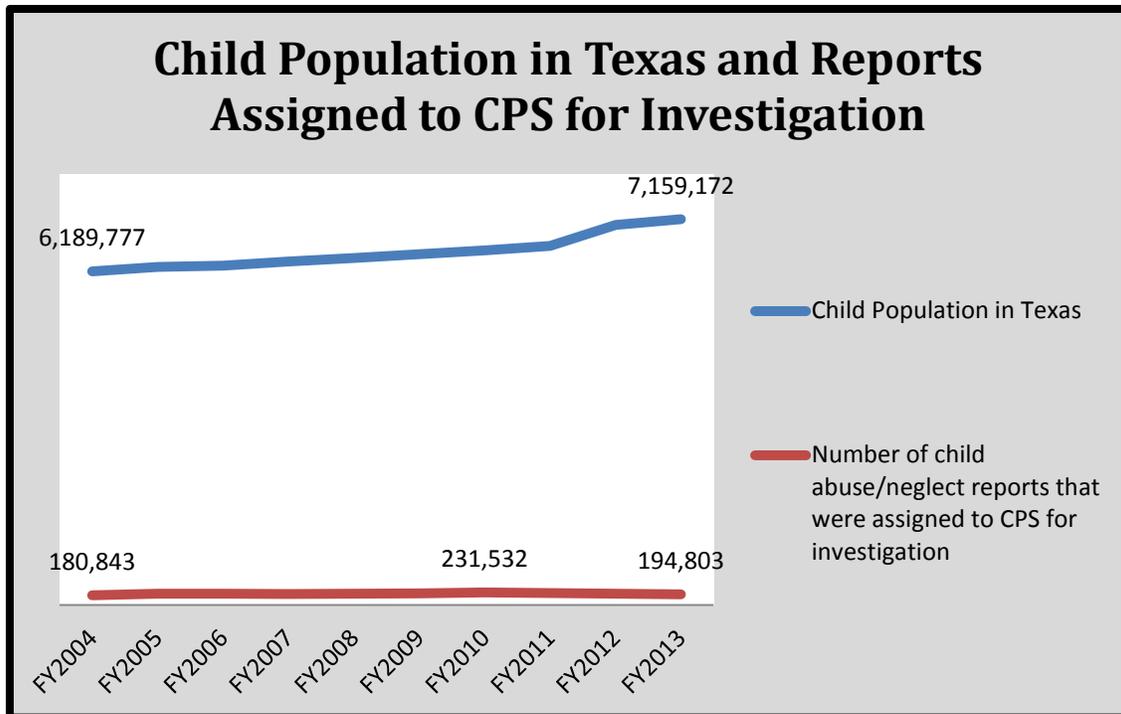
Short-term measures

- Development of a nationally-standardized child death investigation tool
- Require coroners to contract only with forensic pathologists to perform autopsies in at least child and infant deaths, if not all cases
- Require coroners to provide forensic pathologists with all available investigative information and defer to the forensic pathologist in determining cause and manner of death

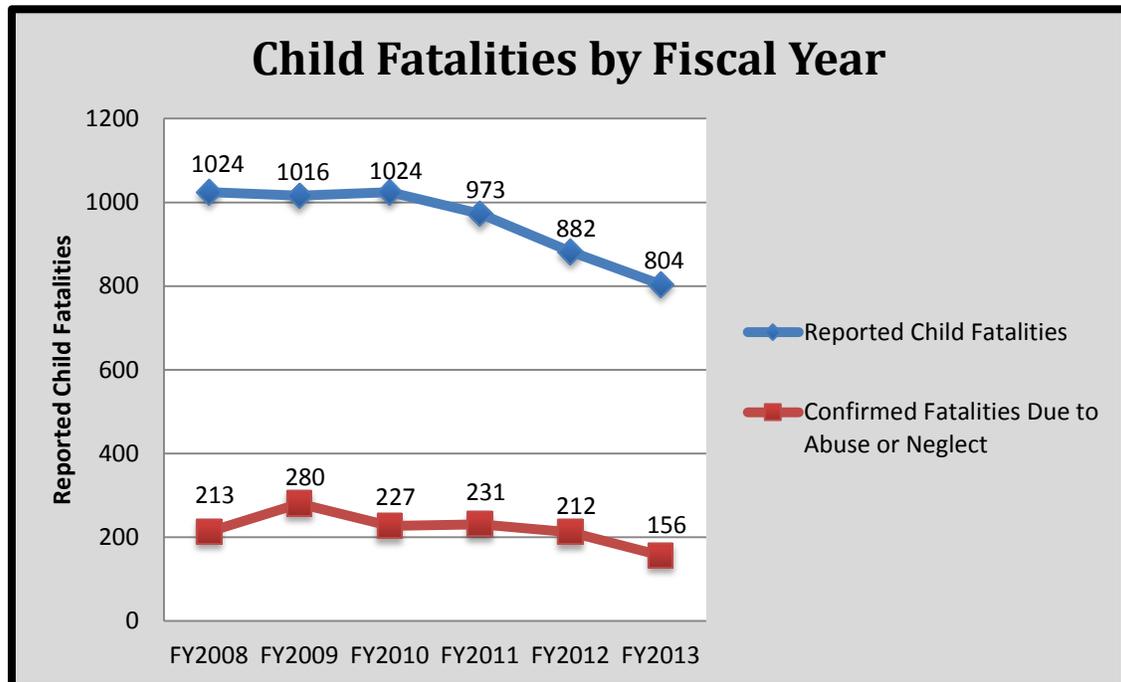
Measurement of Fatal Child Maltreatment

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Chief Medical Examiner
City of Philadelphia



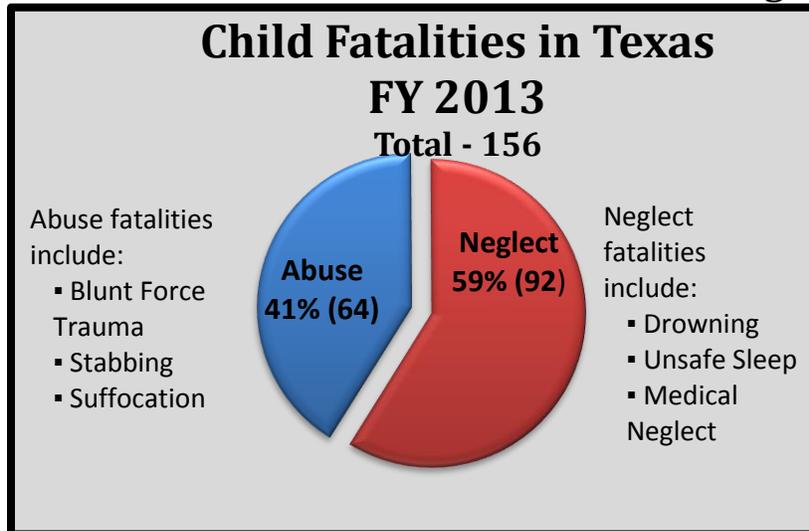


Texas has more than 27 million residents and more than 7 million children. In the past decade, Texas is one of the few states that has continued to increase in population, with more than one million children added in the past decade. Almost one in 10 children in the U.S. live in Texas. About one-third of children in Texas are under 6, which is our most vulnerable population.

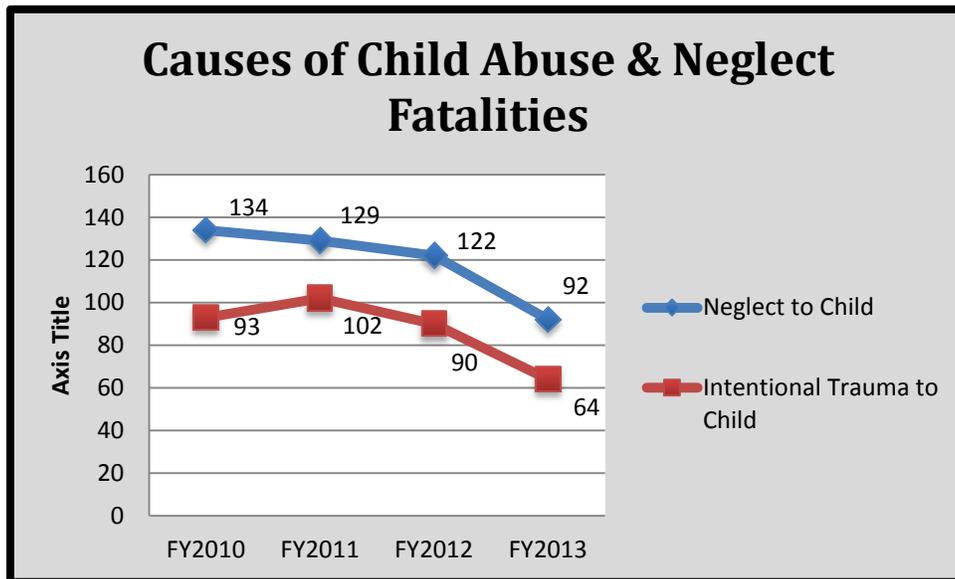


Since 2010, the number of reported child fatalities has been in decline. In 2013, there was a 30 percent drop in child fatalities in the general population in Texas. There were 804 fatalities reported to Child Protective Services (CPS) in 2013 as a result of possible abuse or neglect. Of those cases, 156 were confirmed as fatalities resulting from abuse or neglect. This means that CPS investigated and substantiated that abuse or neglect was the cause of the fatality.

Causes of Child Fatalities Due to Abuse and Neglect



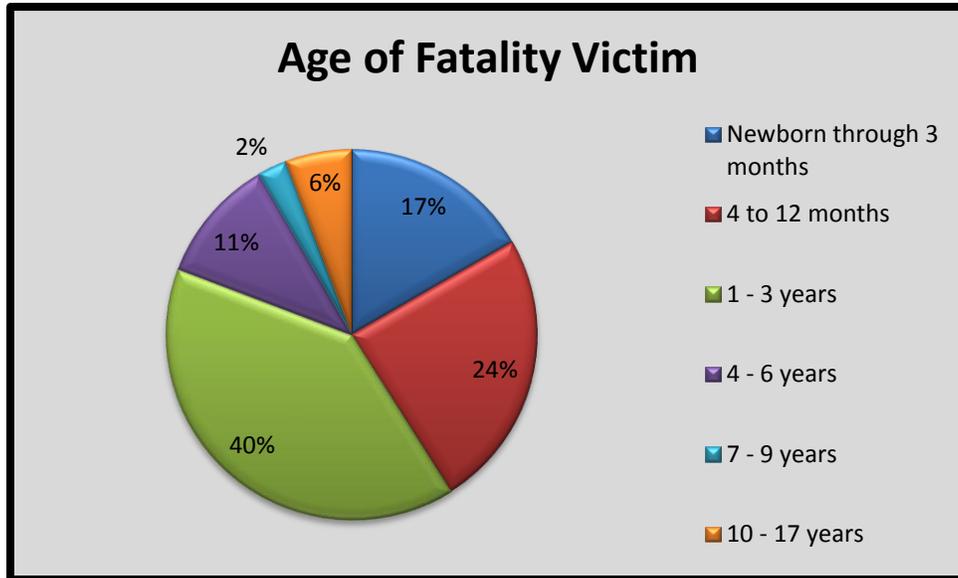
The majority of abuse or neglect child fatalities in Texas can be attributed to neglect, usually an unintentional accident in which the caregiver's inattention or impairment is enough to constitute neglect. Accidental drowning and unsafe sleeping are two of the most common causes of neglect deaths. Abuse occurs when someone intentionally inflicts harm to the child. Of the 64 fatalities caused by abuse, 54 of them were a result of blunt force trauma. This comprises 34 percent of all confirmed fatalities.



Characteristics of Child Fatality Victims of Abuse & Neglect

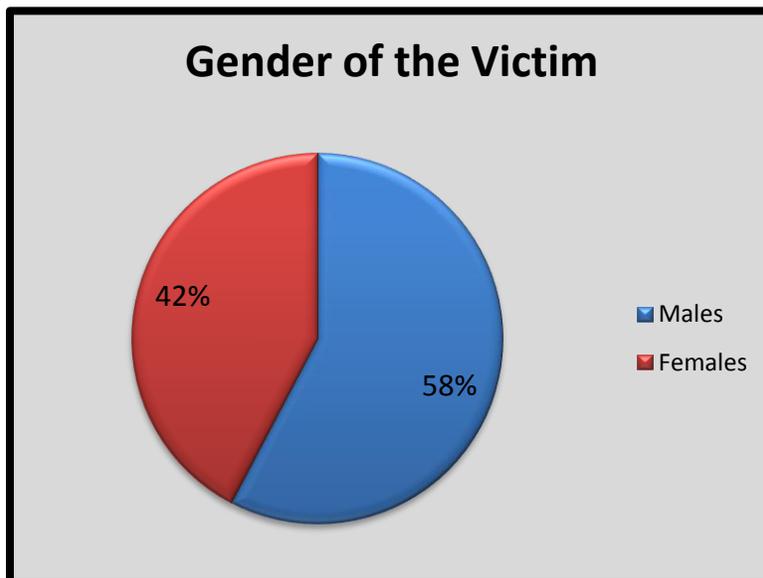
Age

In fiscal year 2013, children 3 years old and younger made up 81 percent of all confirmed child abuse and neglect fatalities. Children under 1 make up half of the fatalities in this age group.



Gender

Males comprised more than half of all child abuse/neglect fatalities.



Federal Commission to Eliminate Child Abuse and Neglect Fatalities

Bexar County Response to Child Abuse and Neglect
Laurie Charles, BSN, RN, SANE-A, SANE-P, CA-CPSANE
June 1, 2014



Bexar Co. Stats, 2012

- 24,476 completed DFPS investigations.
- 13 confirmed victims /1000 children
- 24.5% confirmed investigations with TX
avg. 23.3%.
- 19 child abuse/neglect related fatalities,
one was in foster care.

DFPS (2014).



Forensic Nursing Stats

- 2014 (to date)
 - Sexual assault (SA): 180
 - Physical abuse (PA): 80
 - Consults: 56
- 2013: 889 total
 - SA: 518
 - PA: 217
 - Consults: 154
- 2012: 1087 total
 - SA: 621
 - PA: 280
 - Consults: 186
- 2011: 1070 total
 - SA: 573
 - PA: 293
 - Consults: 204



Texas Strengths

- Texas Family Code § 32.005 Examination without consent of abuse or neglect of child.
- Texas Family Code § 261.301 and Code of Criminal Procedure § 2.27 Investigation of Report.
- Investigation of suspected abuse supersedes HIPAA.



Bexar County Strengths

- Center of Excellence for child abuse assessment, treatment and diagnosis at CH of SA.
 - Experienced forensic nursing team (FNE)
 - Center for Miracles (CFM).
 - Child abuse pediatricians
 - Fellowship program
 - Forensic nurse
 - Social workers
 - Nurse practitioner



Bexar County Strengths

- Working relationship of all team members, especially between FNEs and CFM.
- DFPS liaison co-housed in all four major health systems and at SAPD substations.
- Frequent serious injury staffings between CPS and/or law enforcement and CFM.
- Twice monthly multidisciplinary team meetings.



Bexar Co. Child Fatality Review Team

- Members representatives:
 - Child abuse pediatrician,
 - Nurses and physicians from all major health systems,
 - Juvenile detention,
 - Law enforcement
 - DFPS,
 - Medical examiner's office,
- Mental Health,
- NGOs,
- School district, and
- San Antonio Metro Health District.
- Two members are on state CFRT team.



Bexar Co. CFRT

- Reviews all deaths of children who die in Bexar Co.
 - Non-resident reports forwarded to CFRT where injury occurred for further review.
- Cases brought back if more info needed.
- Community education/PSAs:
 - Water safety: April Pool's Day,
 - Heat awareness,
 - Suicide, and
 - Safe sleep.



- Laurie Charles, BSN, RN, SANE-A,
SANE-P, CA-CPSANE
- (210) 704-3330
- Laurie.charles@christushealth.org

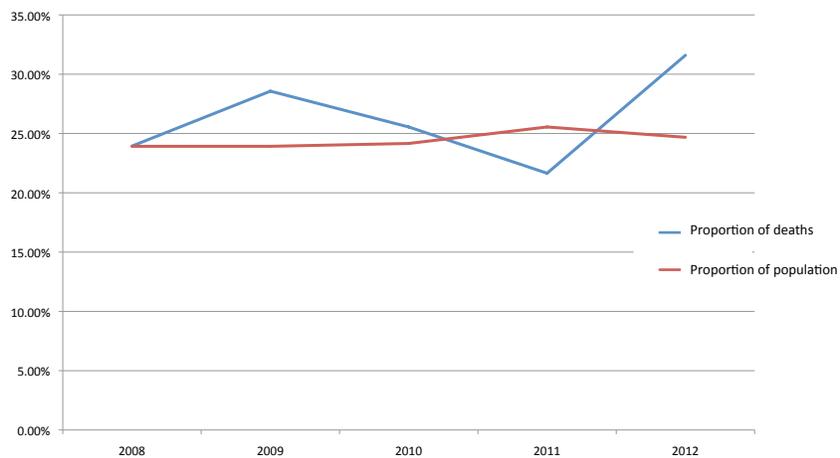




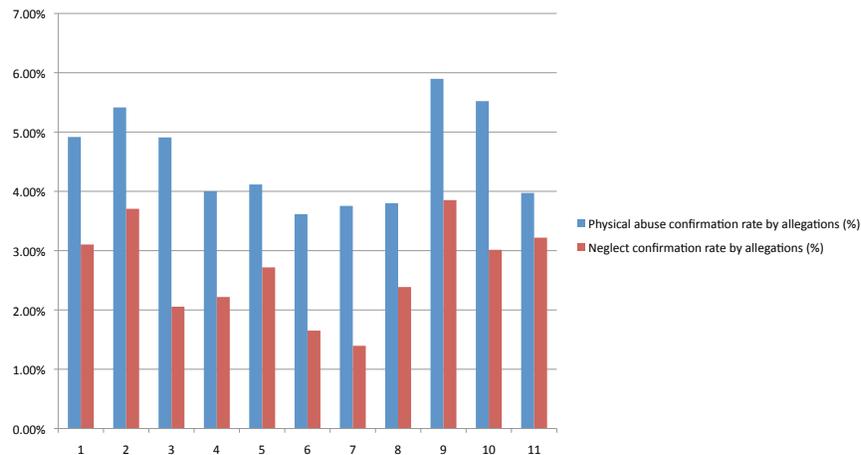
Application of Quality Improvement Methods to a Statewide Child Abuse Network

Rebecca Girardet, MD, Sheela Lahoti, MD,
and Kelly Bolton, UT-Houston HSC
James Lukefahr, MD, UT-San Antonio HSC
Patti Patterson, MD, Texas Tech HSC

Region 6 share of state child maltreatment deaths vs. proportion of child population



Confirmed Cases by Region, FY 2012



Confirmation rates have been consistently lower every year since FY 2010 in regions 4 – 8 despite...

- Similar protective service worker caseloads
- Similar worker turnover
- Similar types of cases
- Numbers of alleged cases proportional to child population was slightly lower in regions 4 - 8

Why are cases “unconfirmed”?

- Ruled out
- Unable to complete
- Unable to determine
 - Unable to determine whether maltreatment occurred, or unable to determine who did it?

Region 6 CPS Workers’ Perceptions of Factors that Adversely Impact the Ability to Make Determinations

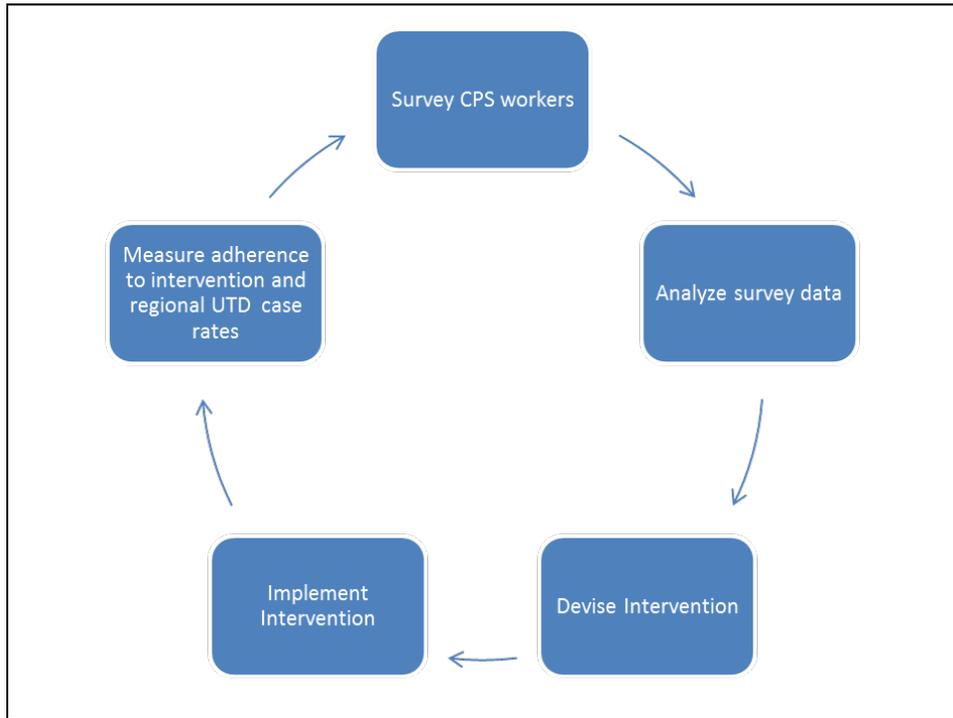
Case characteristics	Documentation issues	CPS issues	Non-CPS professional issues
There is insufficient supporting medical evidence	CPS workers have difficulty obtaining medical records	Caseworkers are overburdened	Availability of child abuse pediatricians is sometimes limited
Injury is “nonspecific” for maltreatment	Medical documentation is incomprehensible to CPS workers	Caseworkers have insufficient training to handle complicated cases	Communication among key players (medical providers, law enforcement, social workers) is poor
A perpetrator cannot be identified	Medical providers do not provide clear documentation outlining the case for maltreatment	Caseworkers are disillusioned when the reality of their jobs is compared to information that they were given in new hire training	Knowledge and helpfulness of physicians is variable
	Medical information is not transferred when the case is moved from one CPS unit to another	There is high turnover of CPS workers due to high levels of job stress, low pay, and the fact that many people choose to work for CPS only as a temporary measure to obtain benefits	
	CPS workers do not document adequately		

Research Design and Methods

- Examine rates of “unable to determine” cases in regions with low and high case confirmation rates (1, 6, 8, and 9)
- Primary study tool is a survey of CPS workers regarding their knowledge and attitudes about medical expertise in child maltreatment in their area
- Devise local strategies for addressing identified needs at 6-month intervals

Sample survey questions

- Please rate how confident you are in knowing when to refer a child with an allegation of physical abuse to a child abuse pediatrician
- I would invite a child abuse pediatrician to a family team meeting concerning a child with medical needs
- I would refer the sibling of a physically abused child to a child abuse pediatrician for an at risk evaluation
- When a child’s case is transferred to a new worker, it is important to notify the child’s primary physician
- It is easy to contact a child abuse pediatrician in my region
- The FACN is responsive to my needs
- Please rate how confident you feel about your ability to make the correct determination in a physical abuse case



the Forensic Assessment Center Network

FACN Home About FACN Consultations Training Partners Resources Contact FACN >Login

Promoting health and safety for children who are suspected victims of abuse or neglect.

FACN Online
● DFPS ● Physicians & Coordinators
[Username Field]
[Password Field]
 Remember Me
Forgot Your Password?
If you are logging in as a DFPS user, your username and password are the same ones used to access IMPACT
If you are a DFPS employee and unable to access the FACN site, contact us at FACN@dfps.state.tx.us.

What is FACN?
The Forensic Assessment Center Network (FACN) is a coordinated group of physicians from six medical schools in Texas who are experts in child abuse and neglect.
A joint project of the Department of Family and Protective Services and the University of Texas Health Science Center-Houston, the FACN provides 24-hour support for CPS investigative staff via a statewide toll free number and a web-based system. FACN physicians also provide ongoing education to CPS workers about medical aspects of child maltreatment.

How does it work?
Physicians are available 24 hours a day, seven days a week to answer questions and make recommendations on acute child maltreatment cases and during regular business hours to review...

Our Mission
Our mission is to promote the health and safety of Texas' most vulnerable children by providing expert consultation for suspected victims of child abuse and neglect.

Contact Us
Forensic Assessment Center Network
1-888-TX4-FACN
FACN@uth.tmc.edu

Testimony before the
**Commission to Eliminate Child Abuse
and Neglect Fatalities**

**Preventing Fatal Child Abuse: Targeting
Resources to Do the Most Good**

Christopher S. Greeley, MD, MS

Professor of Pediatrics

University of Texas Health Science Center at Houston

Chair, Texas Statewide Blue Ribbon Task Force

June 3rd, 2014
University of Texas at San Antonio,
Downtown Campus



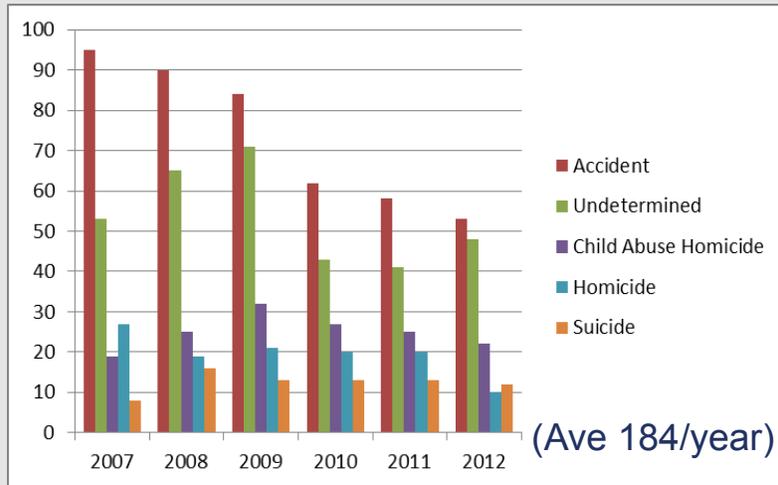
Outline

- Texas state child abuse fatality data
- Houston child abuse surveillance data
- Population level approach to child abuse fatality prevention



Number and Manner of Child Deaths

(Excluding Natural Manner)

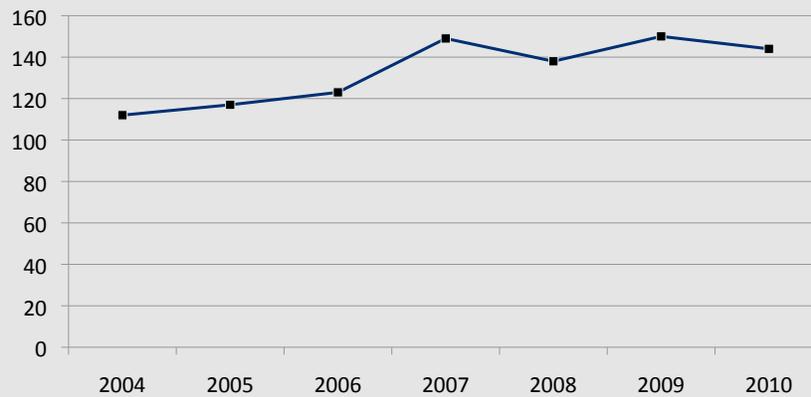


Rodriguez, Texas Department of State Health Services



Number of Hospital Diagnoses of Abusive Head Trauma (AHT) in Texas

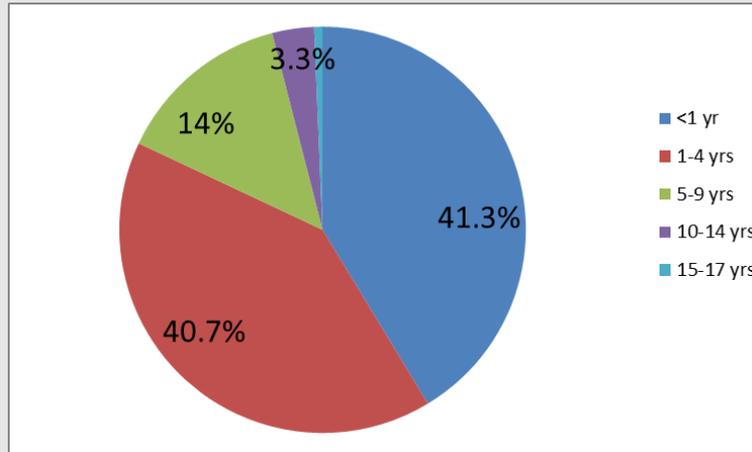
CDC Broad Definition



Texas Hospital Inpatient Discharge Data
Greeley, University of Texas at Houston (unpublished)



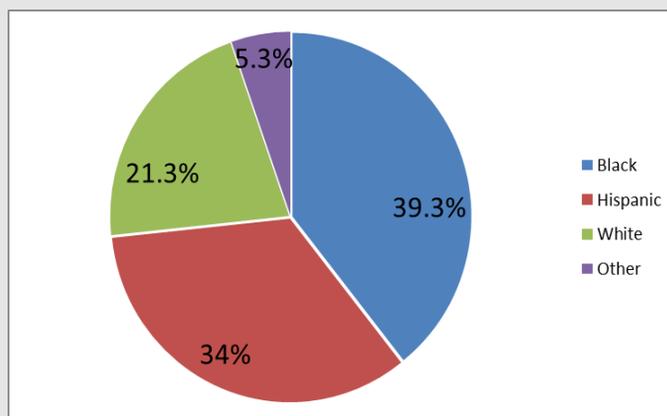
Child Abuse Homicide by Age (Ave 25/year)



Rodriguez, TDSHS

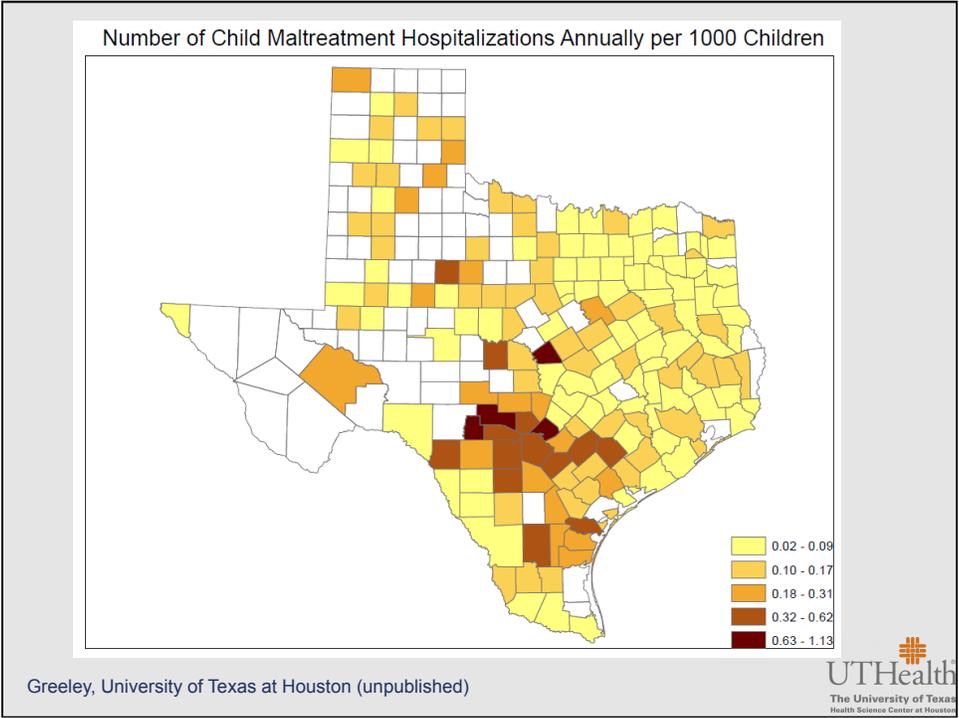
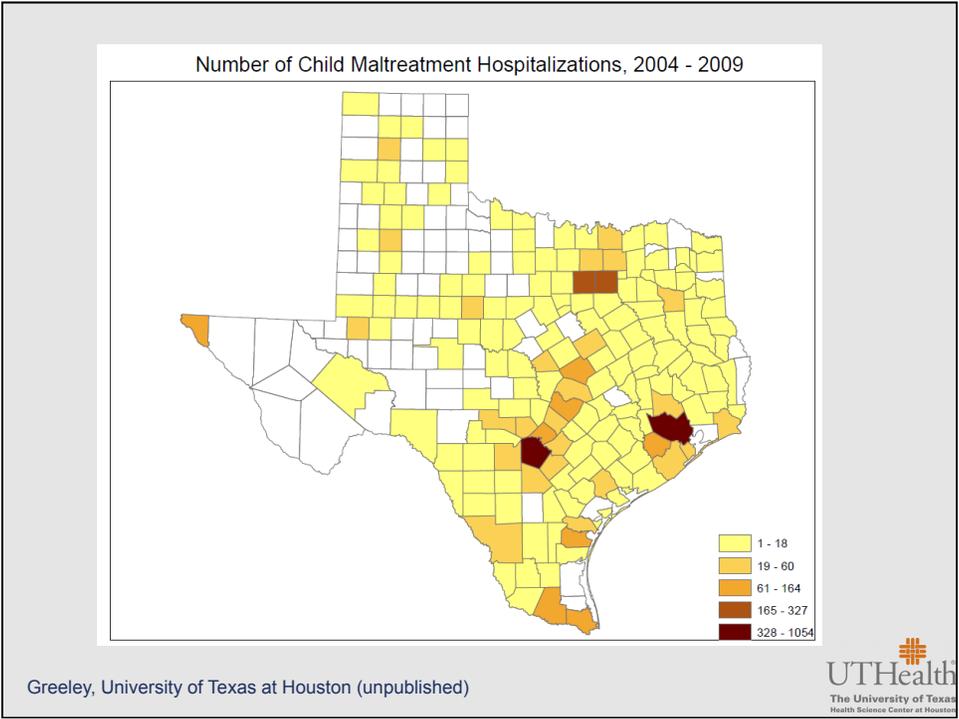


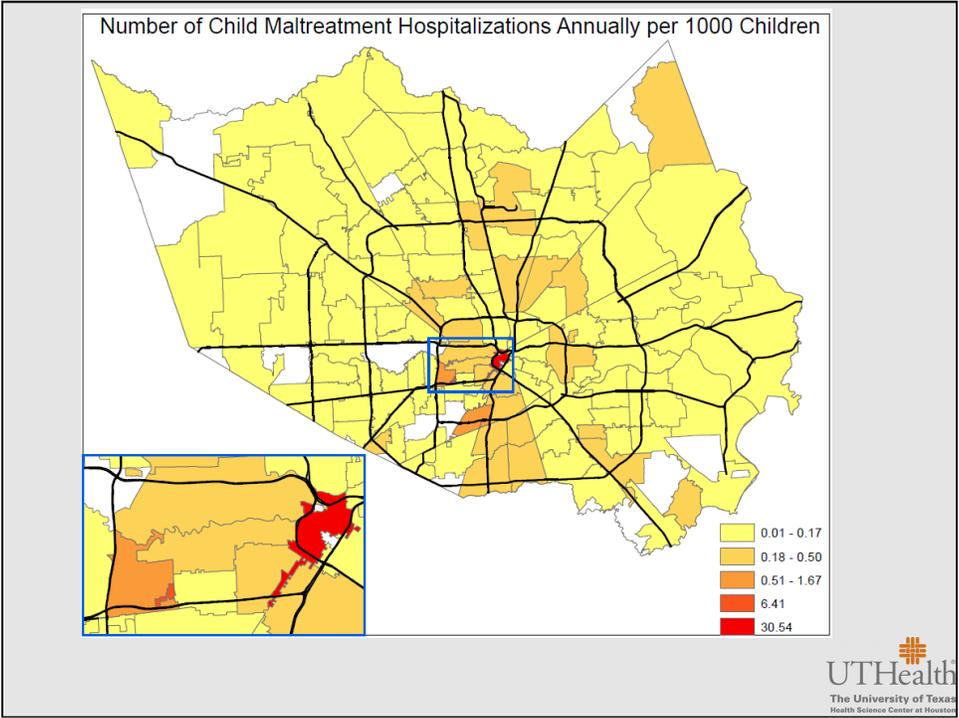
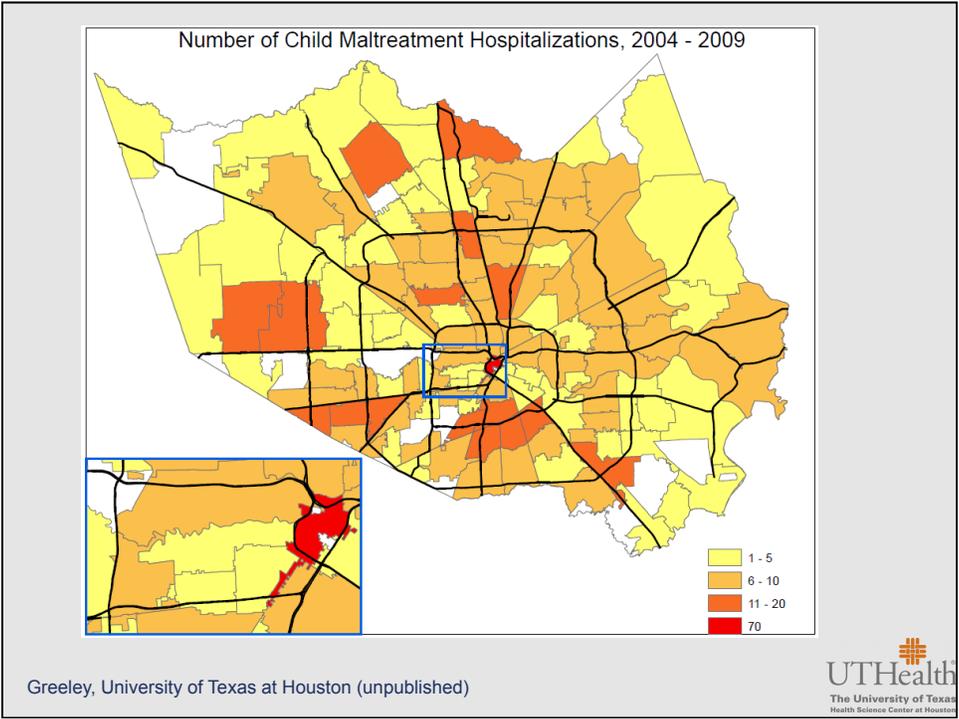
Child Abuse Homicide by Race (Ave 25/year)

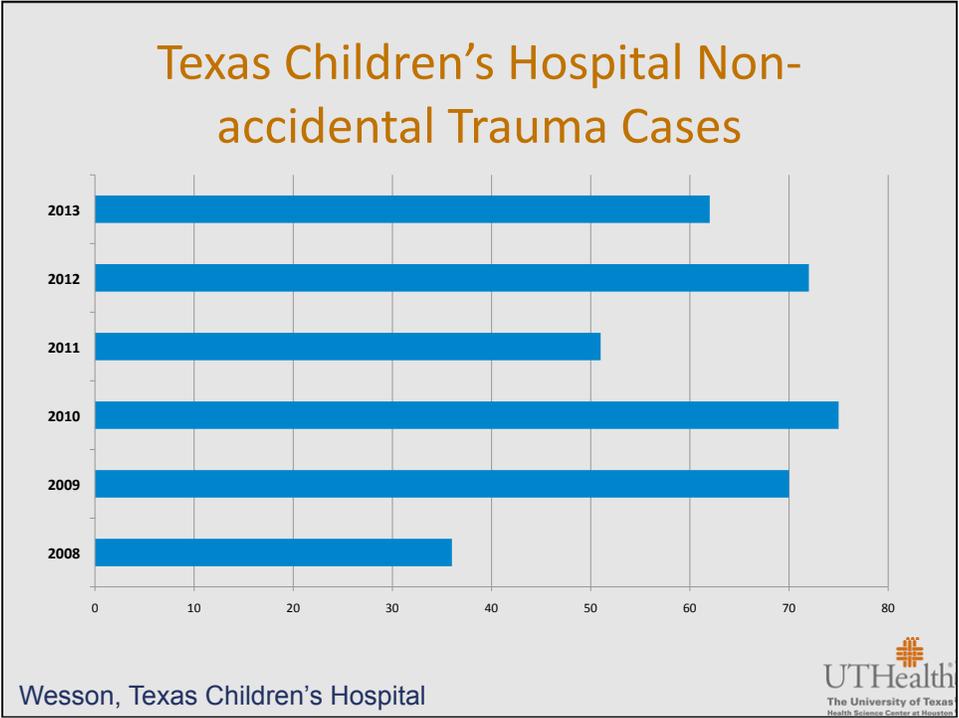
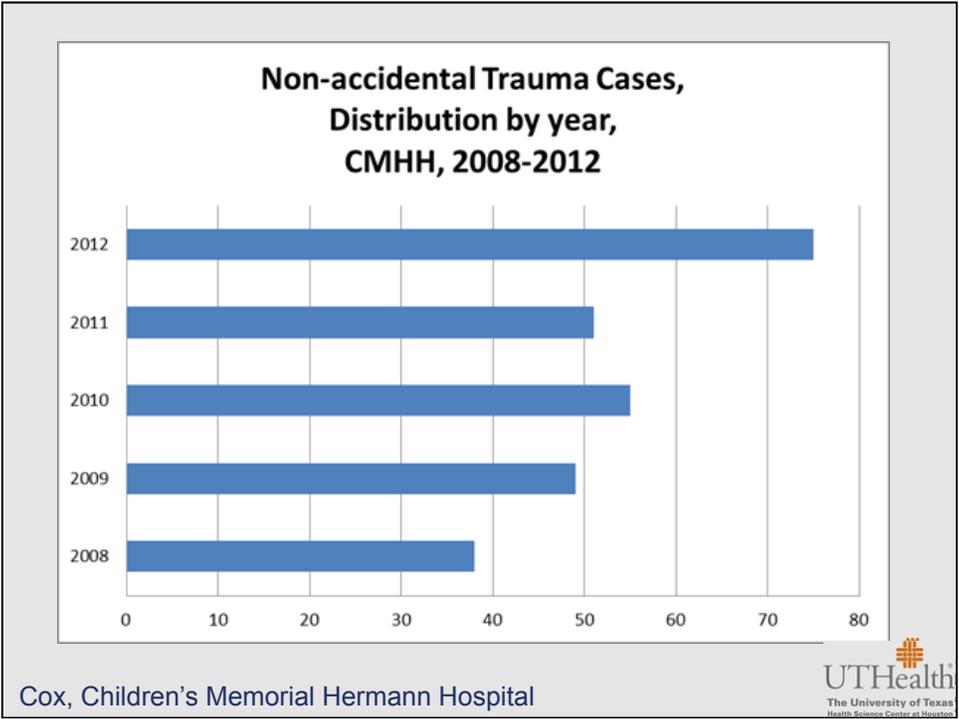


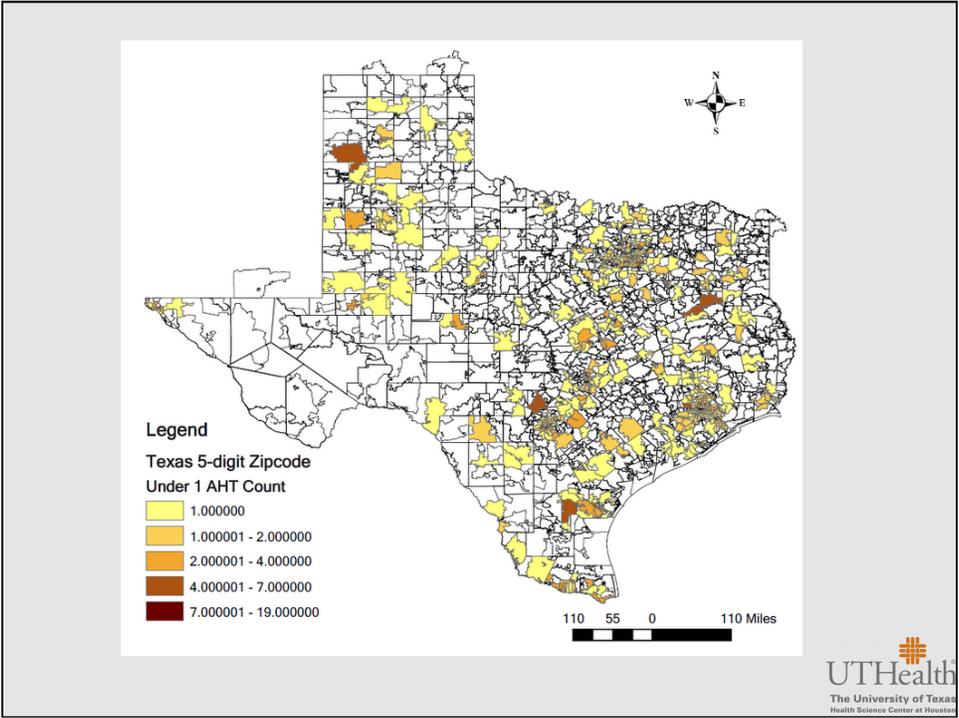
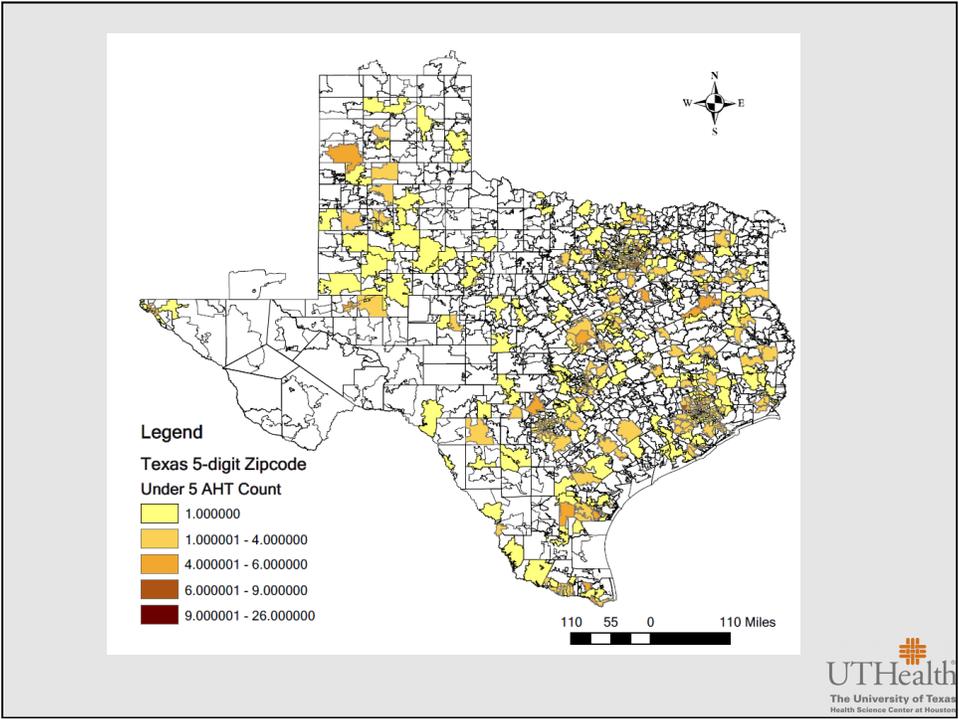
Rodriguez, TDSHS

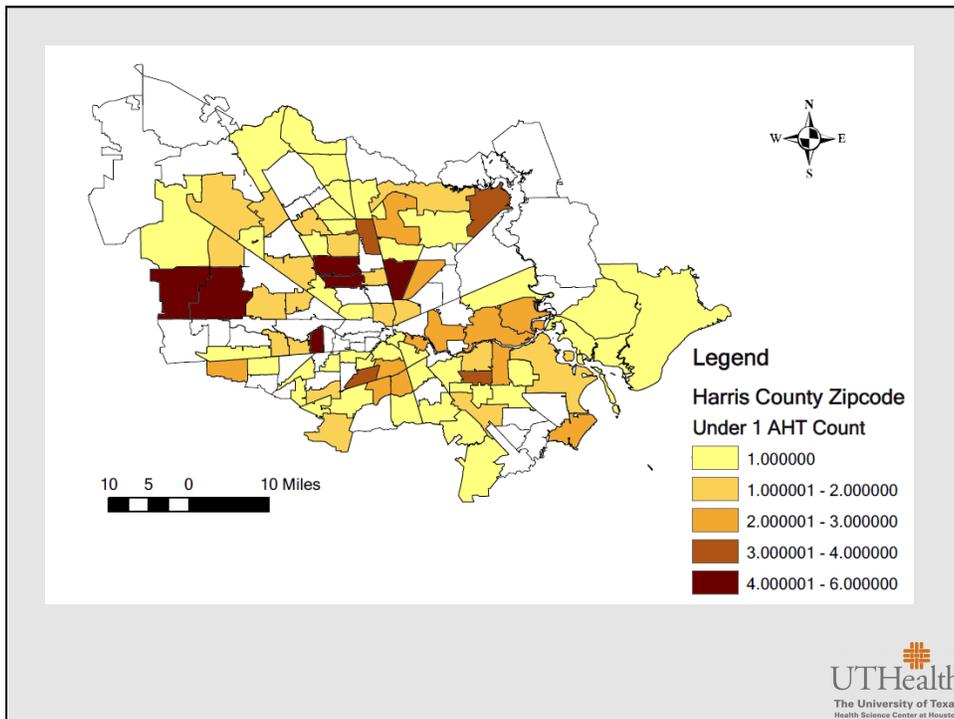
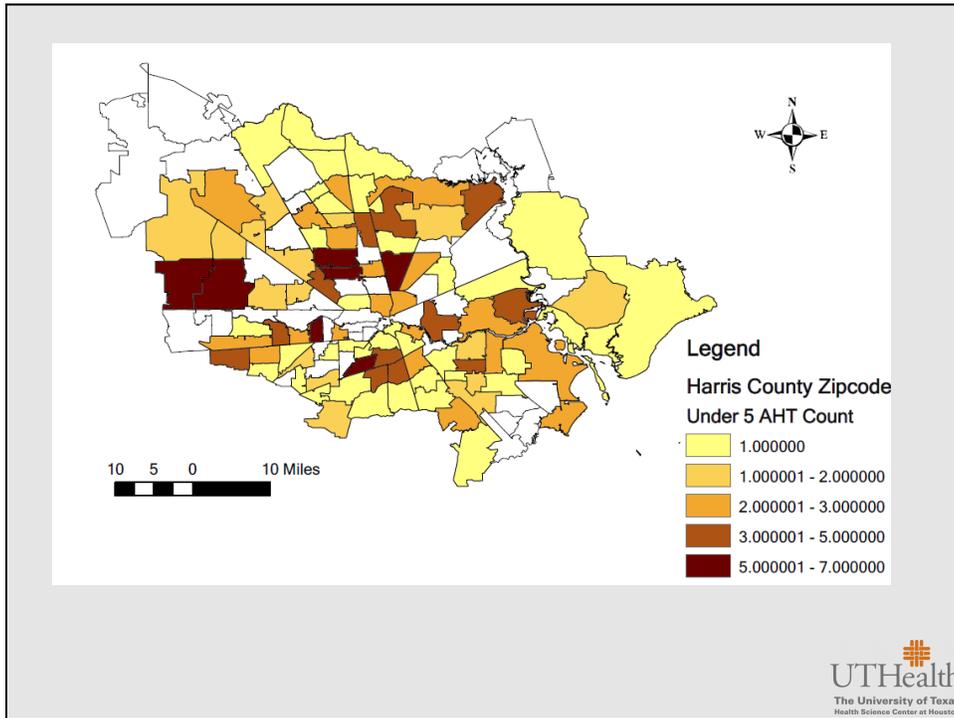










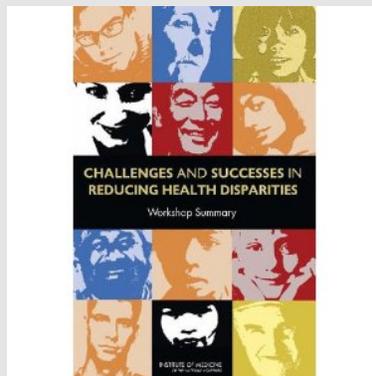


Frameworks of Prevention

- Primary, Secondary, Tertiary
 - Also referred to as Individual, Targeted, Universal
- Reframing of the problem
 - Population level approach to AHT prevention

Neighborhoods as the Focus of Health Disparities

While to a large extent the nation's health care policy is determined by policies instituted by individual states, research from such disciplines as social epidemiology and human development shows that neighborhoods have an impact on children's health and their developmental outcomes, above and beyond individual- and family-level factors.



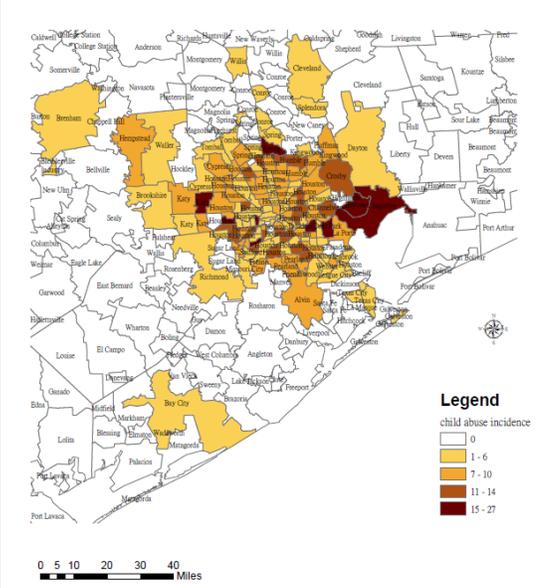
The Population Level Approach

- Primary prevention focus
- Population focused (rather than individual)
- Multidisciplinary
- Action-oriented
- Relies on:
 - Evidence to solve problems
 - Systematic approaches to planning and evaluating interventions

CFRT Child Abuse Death Data (2008-2012)

Contributing Factors	Total
Drug/alcohol impaired at time of incident	20
History of substance abuse	51
History of child maltreatment as victim	18
History of child maltreatment as perpetrator	56
History of intimate partner violence as victim	14
History of intimate partner violence as perpetrator	31
Disability or chronic illness	14

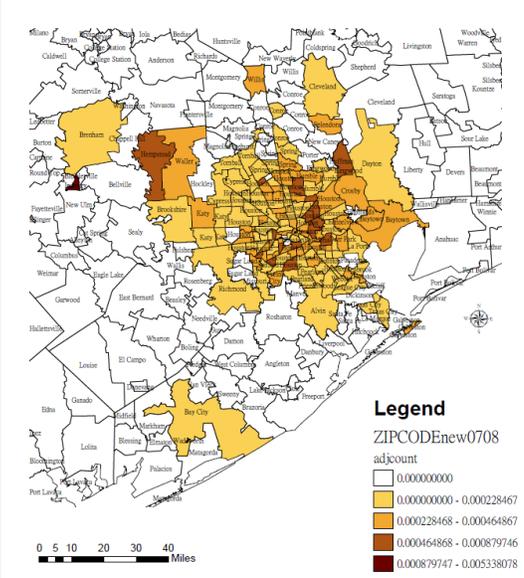
Incidence in Houston Area, 2009



Greeley, Chuo, Kwoh ,et al (under review)



Incidence density in Houston Area, 2009



Greeley, Chuo, Kwoh ,et al (under review)



Zip Code Socioeconomic Characteristics

Characteristics	U.S. Average	Texas Average	Houston Average
Average family size	3.19	2.79	3.26
Average household size	2.60	3.37	2.75
Unmarried partner at household (%)	2.2	1.8	1.6
Nonrelative household member (%)	12.2	12.8	12.4
Problematic marriage (%)	18.7	18.5	19.3
Female divorce rate (%)	11.8	12	11.3
15-19 fertility rate(%)	27	44	45
Grandparents responsible for taking care of child (%)	40.3	44.9	47.8
Education level high school or higher (%)	85.4	80.4	79.8
Veteran population (%)	9.6	9.0	9.7
Foreign-born population (%)	12.8	16.2	12.9
Unemployed labor force (%)	5.6	4.7	4.5
Median household income (\$)	52,762	50,920	52,739
Household with food stamp (%)	10.2	11.2	10.8
Family below poverty line (%)	10.5	13.2	12.6
Vacant house unit (%)	12.4	12.2	17.5
New resident (moved in with 5 year) (%)	40.1	47.0	40.2
Race/ Ethnicity (%)			
White	64.2	45.8	56.0
Black	12.2	11.5	14.1
Hispanic	16.1	37.2	25.7

Greeley, Chuo, Kwoh ,et al (*under review*)



Risk For Seeking Care for Sexual Abuse Concern

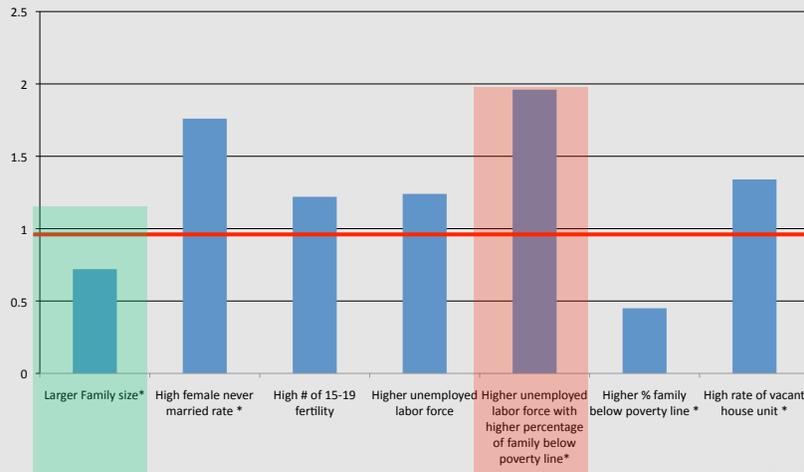
Zip Code Parameter	RR (95% CI)
Larger Family size*	0.72 (0.56,0.92)
High female never married rate *	1.76 (1.35, 2.30)
High # of 15-19 fertility	1.22 (0.97, 1.54)
Higher unemployed labor force	1.24 (0.91, 1.69)
Higher unemployed labor force with higher percentage of family below poverty line*	1.96 (1.12, 3.41)
Higher % family below poverty line *	0.45 (0.25, 0.82)
High rate of vacant house unit	1.34 (1.04, 1.72)

Greeley, Chuo, Kwoh ,et al (*under review*)



Risk For Seeking Care for Sexual Abuse Concern

Relative Risk



Greeley, Chuo, Kwoh ,et al (*under review*)



Prevention Strategies

- Home visitation
- Parental support programs
- Maternal mental health
 - Post-partum depression
 - Educational outreach
- Neighborhood/community stressors
 - Household Violence (IPV)
 - Substance Abuse





Targeting Resources to do the Most Good

- Collaboration
 - Academia, government, community groups
- Sophisticated, efficient and useful surveillance
- Neighborhood level tailored approach to child abuse fatality prevention
- Pilot testing strategies to verify benefit

**Where Hope Lives.
Where Healing Begins.**



For over 130 years, St. Peter-St. Joseph Children's Home (St. PJ's) has been a safe haven for children, ages birth to 17, who have been abused, abandoned and/or neglected. Originally founded as an orphanage by the Sisters of Charity, St. PJ's provides a continuum of services, to meet each child's basic needs and are also provided counseling, case management, and life skills services. St. PJ's is committed to healing children exposed to maltreatment through the following programs.

Every Child. Every Step. Every Day.



ST. PETER - ST. JOSEPH CHILDREN'S HOME

1 EMERGENCY SHELTER

St. PJ's provides emergency services for 20 domestic children, birth to 17 years

2 LONG-TERM RESIDENTIAL

St. PJ's is licensed by the TDFPS as a long-term residential facility able to accept of up to 38 children, ages 5 to 17.

3 TRANSITIONAL LIVING PROGRAM

The TLP provides life skills training to successfully make the transition to independence.

4 FOSTER CARE & ADOPTION

St. PJ's is a licensed Child Placing Agency providing recruitment, training and support to foster, foster to adopt and adoptive families.

5 COUNSELING CENTER

Services include trauma assessment, individual, family, sibling counseling, group therapy; counseling and other support services.

6 FAMILY CRISIS SUPPORT SERVICES

This program assists low-income families in crises by providing services and referral services to address basic needs or housing assistance.

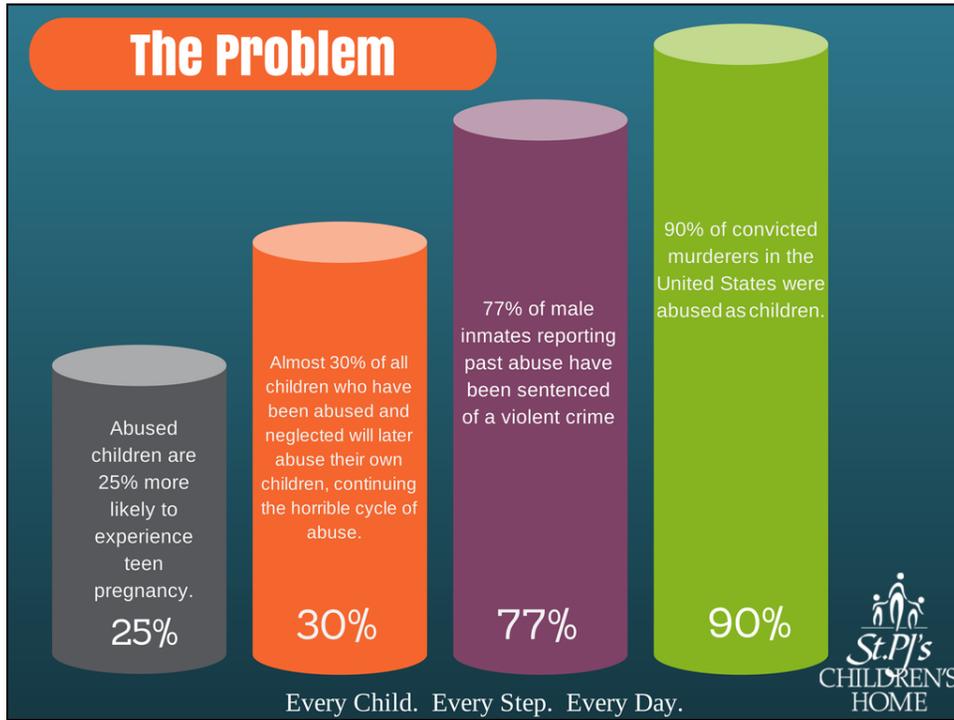
6 INTERNATIONAL EMERGENCY SHELTER

St. PJ's is licensed for short-term Emergency Shelter for 82 international children, birth to age 17, who are victims of abuse, neglect and human and sex trafficking.

***Over 1,500 Served Each Year**

Every Child. Every Step. Every Day.





Mental Health Should Be Treated With The Same Urgency as Physical Health

St. P.J.'s intends to bring an equal sense of **URGENCY** to the trauma related developmental/emotional/behavioral harm that occurs with the physical injuries caused by abuse and neglect.

Two years ago, The Texas Department of Family and Protective Services began focusing on the long term effects of child maltreatment by initiating training on child traumatic stress for CPS staff as well as the community providers. The Adverse Child Experiences (ACE) study found that multiple adverse childhood experiences resulted in poor physical and mental health outcomes as adults.

St. P.J.'s realizes the **URGENT** need to address a child's mental health once entering the state's care. Currently, the mental health of children who have suffered maltreatment is not addressed as urgently as the children's physical well-being.




Every Child. Every Step. Every Day.

14-Day Model of Healing

- ➔ There must be the same urgency to address the traumatic impact of abuse/neglect on the mental health of the child as there is to protect the physical well-being of the child
- ➔ Agencies must have access to the bio family (phone) within the first 3 days to gather developmental history/experiences of the child. This information must contribute to the overall evaluation/assessment of the child.
- ➔ Therapists and Case Managers must complete all assessment reports no later than the 10th day so they can be entered into the Clinical Online Assessment Tool (COAT).
- ➔ The Global Intervention Plan (GIP) along with the Neurosequential Model of Therapeutics (NMT – brain map) report, must be completed no later than the 14th day. Caregivers must fully understand how the abuse/neglect has affected brain function.

“No longer are caregivers just getting children to their counseling, psychiatrist appointments or taking parenting classes. Now, they are a vital part of the treatment team.”

- James Castro, CEO St. PJ's Children's Home

Every Child. Every Step. Every Day.





Congressional Research Service
Informing the legislative debate since 1914

Federal Child Welfare Programs

with a Focus on Congressional Interest in Safety of Children and Child Abuse and Neglect Fatalities

June 2, 2014

Agenda

- Opening Notes
 - Selected Key Child Welfare Legislation
 - Responsibility for Child Protection
 - Overview: Federal Child Welfare Goals, Programs and Funding
 - CAPTA, Title IV-B, and Title IV-E
 - General Purpose Grants and Medicaid
 - Program Relationships
 - Additional Programs of Interest
 - Children and Families Coming Into Contact with Child Welfare
-



CRS-2

Opening Notes

- A primary role of child welfare agencies is to identify and serve families with greatest need (“dysfunction”).
- Federal role in child protection has limits and is sometimes contested.
- Federal policy sets the safety of children as a paramount concern of child welfare decisionmaking.
- Most federal support to states for child protection is dedicated to protecting children by removing them from their homes (foster care).
- Explicit focus in federal child welfare policy on child abuse and neglect fatalities is limited.



CRS-3

Selected Key Legislation Concerning Child Welfare

The following sketch of enacted provisions is meant to highlight creation of programs, major program shifts, and items directly related to child abuse and neglect fatalities. It is not comprehensive. Many additional child welfare and relevant related laws, have been enacted, especially during the 2000s, which are not noted here.



CRS-4

Selected Key Legislation Concerning Child Protection – Early Years

Unless otherwise noted all references to Titles or Parts of the law are made to the Social Security Act

1912 - Children's Bureau created to "investigate and report . . . upon all matters pertaining to the welfare of children and child life among all classes of our people."



1935 - Aid to Dependent Children (ADC) (Title IV) and Maternal and Child Welfare (Title V) grants included in original Social Security Act. (Title V, Part 3 was known as Child Welfare Services (CWS)).

1956 - Federal reimbursement for "social services" added to ADC.

1961 - ADC assistance allowed to follow a child moved to a foster family home. (Authority made "permanent" in 1967.)

1962 - ADC renamed as Aid to Families with Dependent Children (AFDC); under CWS, states must aim to offer services of trained professional on a statewide basis by July 1, 1975.

1965 - Medicaid established (Title XIX).

1967 - CWS program moved to a new Title IV-B; Emergency Assistance (EA) added to AFDC; Early and Periodic Screening, Diagnostic and Treatment Program (EPDST) required under Medicaid.



CRS-5

Selected Key Legislation Concerning Child Protection – 1970s- 1980s

Unless otherwise noted all references to Titles or Parts of the law are made to the Social Security Act

1974 - Child Abuse Prevention and Treatment Act (CAPTA) established federal focus on issue; required states to receive and respond to reports of child abuse and neglect and to provide for confidentiality.

1974 - Independent Social Services program (Title XX) enacted with five purposes, including preventing or remedying the neglect, abuse, or exploitation of children and adults; **Child Support Enforcement** program (Title IV-D) established.

1980 - Independent foster care program (Title IV-E) enacted; incentive funds offered, under CWS, for states to strengthen child protections.

1981 - Title XX rewritten as the Social Services Block Grant (SSBG); Title V reconfigured as Maternal and Child Health Services block grant.

1984 - Crime Victims Fund established, providing support to victim assistance programs in each state, including those for victims of child abuse, spousal abuse or sexual assault.

1986 - State grants for Infants and Toddlers with Disabilities created (now Part C of the Individuals with Disabilities Education Act, IDEA).

1988 - Presidential Commission on Child and Youth Deaths authorized (never funded).



CRS-6

Selected Key Legislation Concerning Child Protection – 1990s

Unless otherwise noted all references to Titles or Parts of the law are made to the Social Security Act

1990 - Victims of Child Abuse Act authorized funds to improve court handling of child abuse and neglect cases, Court Appointed Special Advocates, and (as specified in 1992) Children’s Advocacy Centers.



1993 – Family support and family preservation services added to Title IV-B (renamed Promoting Safe and Stable Families, 1997); Court Improvement Program created.

1992 – Advisory Board on Child Abuse and Neglect directed to **examine maltreatment-related deaths** of children and youth.

1992 – States required to improve handling of cases of suspected child abuse or neglect-related fatalities, as part of the **Children’s Justice Act** grants (created 1986).

1994 – HHS required to create a more outcome-driven system for determining state compliance with Title IV-B and Title IV-E policies (new reviews, “CFRSs,” initiated in 2001).

1996 – AFDC replaced with Temporary Assistance for Needy Families (TANF); goals include helping needy families maintain children in their homes.

1996 – Federal role in oversight of CAPTA reduced; Citizen Review Panels required.

1997 – Adoption and Safe Families Act established safety as paramount in all child welfare decisionmaking, including termination of parental rights (TPR).



CRS-7

Selected Key Legislation Concerning Child Protection – Recent Years

Unless otherwise noted all references to Titles or Parts of the law are made to the Social Security Act



2006 – States required (under Title IV-E) to conduct fingerprint-based criminal background checks of prospective foster and adoptive parents and to check state child abuse and neglect registries.

2006 – States required (under CWS) to set standards for monthly caseworker visits with children in care; grants to improve outcomes for children with substance abusing parents established.

2008 – CWS and Title IV-E amended to increase focus on health and education outcomes for children in foster care; Family Connection Grants established.

2010 – Maternal Infant and Early Childhood Home Visiting (MIECHV) program established as part of Title V.

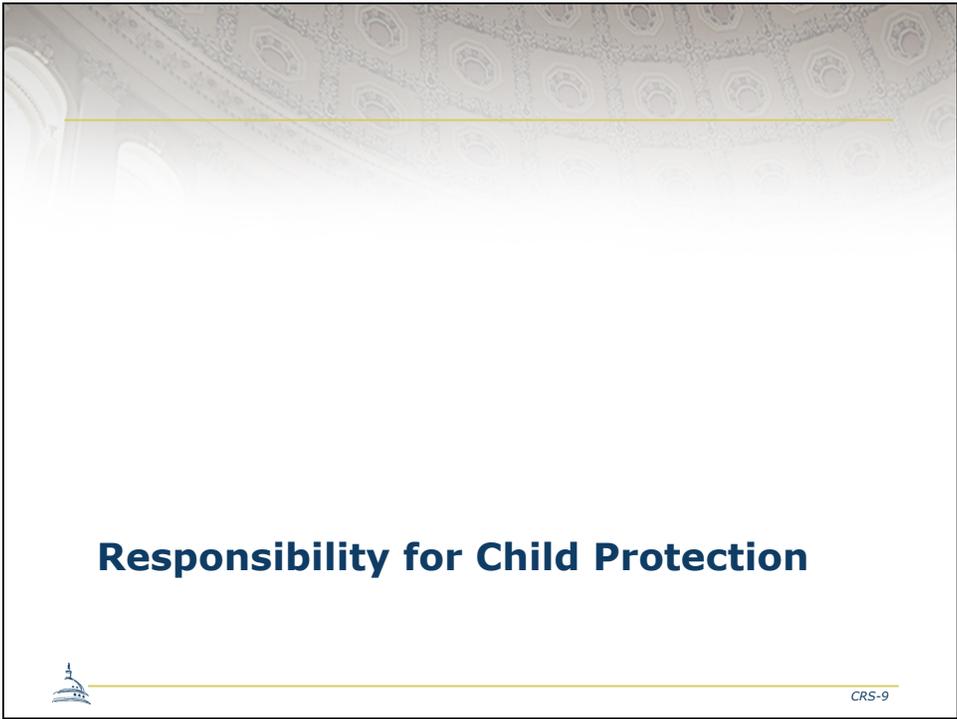
2011 – States encouraged, under CWS, to provide more comprehensive data on child abuse and neglect-related fatalities; child welfare “waiver” authority renewed (for three years only).

2012 – Commission to Eliminate Child Abuse and Neglect Fatalities authorized.

2014 – Attorney General required to report on state penalties for child abuse, including whether there are enhanced penalties when victim suffered serious bodily injury or permanent or protracted loss/impairment of mental or emotional function.



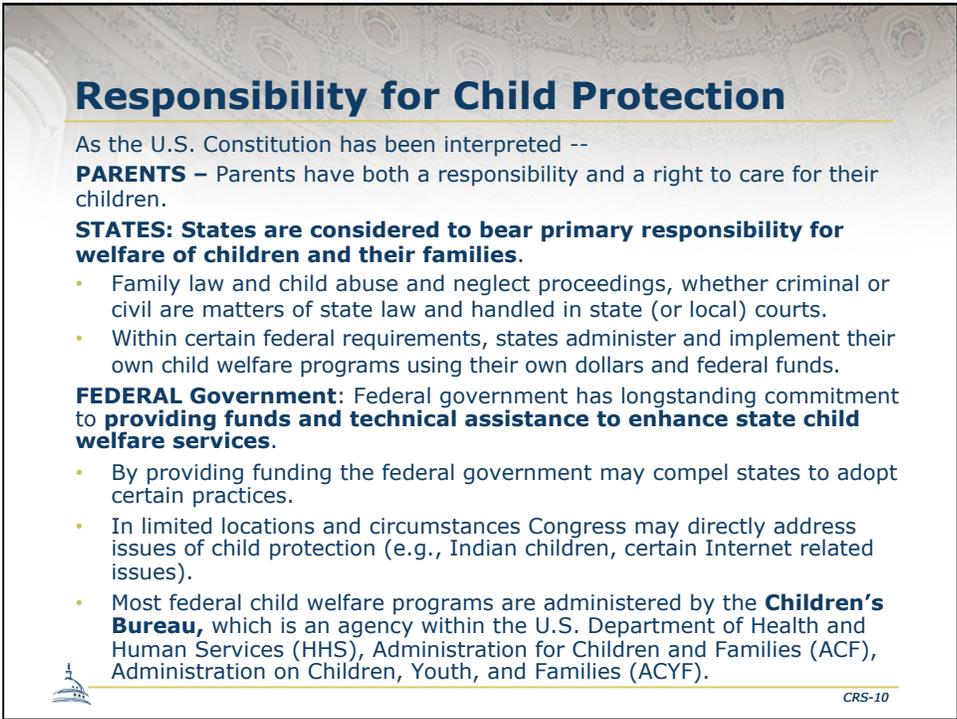
CRS-8



Responsibility for Child Protection



CRS-9



Responsibility for Child Protection

As the U.S. Constitution has been interpreted --

PARENTS – Parents have both a responsibility and a right to care for their children.

STATES: States are considered to bear primary responsibility for welfare of children and their families.

- Family law and child abuse and neglect proceedings, whether criminal or civil are matters of state law and handled in state (or local) courts.
- Within certain federal requirements, states administer and implement their own child welfare programs using their own dollars and federal funds.

FEDERAL Government: Federal government has longstanding commitment to **providing funds and technical assistance to enhance state child welfare services.**

- By providing funding the federal government may compel states to adopt certain practices.
- In limited locations and circumstances Congress may directly address issues of child protection (e.g., Indian children, certain Internet related issues).
- Most federal child welfare programs are administered by the **Children’s Bureau**, which is an agency within the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Administration on Children, Youth, and Families (ACYF).



CRS-10

Overview: Federal Child Welfare Goals, Programs and Funding



CRS-11

Overview: Federal Child Welfare Policy Goals; Activities Supported

Children are protected from abuse and neglect (**SAFETY**). They have a stable and loving family (**PERMANENCE**). Children's families are strong and children's physical, social, and educational development is nurtured (**WELL-BEING**).

- Federal policy requires states to make "reasonable efforts" to keep most children and their parents together, although the **child's safety must be "paramount" in all child welfare decisionmaking.**
- More than half of all children who leave foster care each year do so to be reunited with their parents.
- Most federal funds dedicated to child welfare are available once a child is removed from the home and/or for placement in a new home.

SERVICES AND ACTIVITIES SUPPORTED

Services to **strengthen families** and **prevent child abuse and neglect.**

Investigation of child abuse or neglect allegations.

Services to **permit children and parents to remain together**, or be reunited.

Placement in foster care; assistance, case planning and review.

Placement in permanent home (via reunification, adoption, or guardianship).

Post-permanency supports.

Services to **help youth successfully transition from foster care to adulthood.**



CRS-12

Overview: Federal Child Welfare Programs and FY2014 Dedicated Funding

TITLE IV-B OF THE SOCIAL SECURITY ACT (\$674 million)

Funds a broad range of state and tribal child welfare-related services to children and their families via the **Stephanie Tubbs Jones Child Welfare Services Program** and the **Promoting Safe and Stable Families Program**; also supports some child welfare-related research, and demonstrations and training.

TITLE IV-E OF THE SOCIAL SECURITY ACT – (\$7.090 billion)

Reimburses states and tribes for a part of all eligible costs related to provision of **Foster Care**, **Adoption Assistance**, and (at state option) **Kinship Guardianship Assistance**, and supports tribal IV-E plan development grants; authorizes formula grants for services to youth aging out of foster care under the **Chafee Foster Care Independence Program**, including for Education and Training Vouchers and for **Adoption Incentives**

Remaining dedicated federal child welfare dollars authorized under the **Child Abuse Prevention and Treatment Act (CAPTA)** (\$94 million), **Children’s Justice** (\$20 million), Adoption Opportunities (\$41 million) and Abandoned Infants Assistance acts (\$11 million) (handled by House Education and the Workforce and Senate Health Education Labor and Pensions committees); as well as the **Victims of Child Abuse Act**, including support for Children’s Advocacy Centers, Court Appointed Special Advocates and child-abuse related training for judicial personnel (total: \$27 million)(handled by House and Senate Judiciary committees).

Most of the roughly \$8 billion in dedicated federal child welfare funding is -

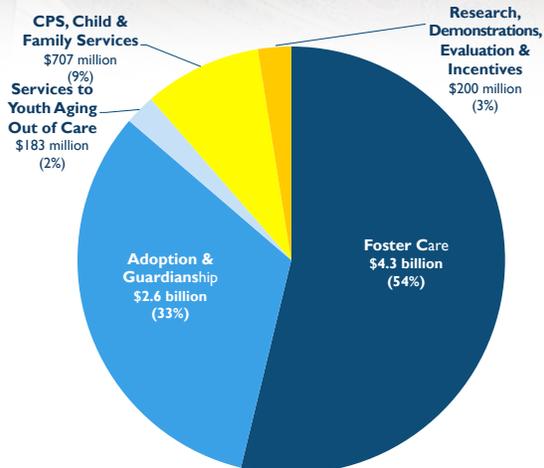
- Authorized under Title IV-B and Title IV-E of the Social Security Act.
- Paid to state child welfare agencies.
- Conditioned on program requirements included in those parts of the law.
- Handled by the House Ways & Means and Senate Finance committees



CRS-13

Federal Funds Dedicated to Child Welfare, by Purpose, FY2014

Total Dedicated Funding: \$8.0 billion



Notes: “Foster Care,” and “Adoption & Guardianship” funding amounts are based on definite budget authority appropriated under Title IV-E to provide reimbursement to states for eligible costs. Funding shown in “Services to Youth Aging out of Care” includes Chafee Foster Care Independence Program and Education and Training Vouchers (both under Title IV-E), and is distributed by formula to all states. Funding shown for “CPS and Child and Family Services,” includes: CAPTA state grants, CBCAP (under Title II of CAPTA), Children’s Justice Act grants, and Title IV-B programs (Child Welfare Services, Promoting Safe and Stable Families (PSSF) funding for child and family services, the Court Improvement Program, and Monthly Caseworker Visit Grants). These program funds are distributed by formula to all states. Funding for research, demonstrations, evaluation and incentives is awarded to various eligible entities on a competitive basis, and includes funding provided for Adoption Incentives, CAPTA discretionary activities, Regional Partnership Grants (under PSSF), Victims of Child Abuse Act programs, child welfare training and research funds under Title IV-B, Subpart 1, PSSF-related research and evaluation, tribal IV-E planning grants and technical assistance under Title IV-E, Adoption Opportunities, and Abandoned Infants Assistance.

Source: Figure prepared by the Congressional Research Service (CRS) based on PL 113-76 (and after application of sequestration.)



CRS-14

Spending by State Child Welfare Agencies, State Fiscal Year 2010

State child welfare agencies spent **\$29.4 billion for all child welfare purposes in state fiscal year 2010**. Of this spending 54% (\$15.8 billion) was state and local dollars and **46% (\$13.6 billion) was federal**.

States supplement dedicated federal child welfare funds with other federal funding that may be spent for child welfare purposes. Notably in SFY2010 this included:

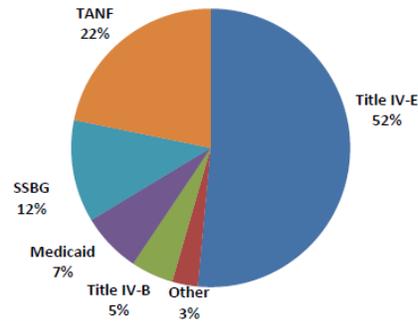
- **\$3.0 billion in Temporary Assistance for Needy Families (TANF)**;
- **\$1.6 billion in Social Services Block Grant (SSBG, includes TANF transfer dollars)**; and
- **\$1.0 billion in Medicaid.***

*Medicaid costs shown here exclude basic health care, and only include certain services specific to child welfare (e.g., targeted case management, rehabilitative services, Medicaid funded therapeutic foster care and their associated administrative costs).



SFY2010 Federal Child Welfare Spending, by Funding Source

Total Federal Expenditures: \$13.6 billion



Source: Kerry DeVooght, Megan Fletcher, Brigitte Vaughn and Hope Cooper, *Federal, State and Local Spending to Address Child Abuse and Neglect in SFYs 2008 and 2010*, Child Trends with the support of Casey Family Programs and the Annie E. Casey Foundation, June 2012.

Notes: Based on data from 48 states, the District of Columbia and Puerto Rico. Excludes Rhode Island (no SSBG data provided) and West Virginia (no Medicaid data provided). SSBG includes TANF funds transferred to SSBG. Title IV-B includes subparts 1 and 2. "Other" includes any other federal dollars not included in other major categories (e.g. CAPTA, Children's Justice Act, Adoption Opportunities) and third-party funds received on behalf of children in foster care (e.g., SSI, SSDI, child support payments).

CRS-15

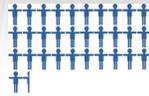
CAPTA, Title IV-B, Title IV-E

All of the programs authorized are administered at the federal level by the Children's Bureau within HHS, ACF, Administration on Children Youth and Families (ACYF).



CRS-16

Children Brought to the Attention of the Child Welfare Agency, FY2012



6.3 million*
Referred to child protective services because of alleged child abuse or neglect.



3.8 million*
Subject of child abuse or neglect investigation or assessment by child protective services (remainder of children referred are "screened out").



1.2 million*
Received some service after the child protective services investigation or assessment ended, including victims and non-victims (79% received services while remaining in the home, 21% received services that included foster care).



686,000
Found by child protective services to be a victim of child abuse or neglect (38% were served in the home following the investigation/assessment,* 23% were placed in foster care,* and 39% received no further service*).



638,000
Spent at least 24 hours in foster care (including children in care when the fiscal year began and those who entered care during the fiscal year due to abuse, neglect, or other reasons).



397,000
Remained in foster care on the last day of fiscal year.

Notes: Each stick figure represents approximately 200,000 children.

* Indicates the number is a "duplicate count." The share of victims by post-investigation service is also based on a duplicate count of victims.

A child was counted each time he/she was referred to CPS, was the subject of an investigation, or assessment or received a post-investigation or assessment service. If this occurred more than once in the fiscal year, the child is counted more than once. This is called a "duplicate" count.

By contrast, the number of children shown as victims of child abuse or neglect is a "unique" count. If a child was found to be a victim more than once, he/she was counted only once in this number. Similarly the counts of children in foster care represent unique children within the fiscal year, day, or average month.

Source: Figure prepared by the Congressional Research Service (CRS) based on U.S. Department of Health and Human Services (HHS) *Child Maltreatment 2012* (December 2013) and "Trends in Adoption and Foster Care," (November 2013).



CRS-17

CAPTA State Grants *FY2014 funding - \$25 million*

States must assure HHS that they have a statewide program or law that:

- **Requires** (and allows) **reports** of known or suspected child abuse or neglect;
- Provides a **response** to such reports **to ensure the safety of children**;
- Ensures **confidentiality** of child abuse and neglect reports;
- Offers **immunity** for good faith reporters;
- Includes **cooperation of law enforcement, courts and state human service agencies** in responding to child abuse and neglect;
- Provides for **citizen review panels** to evaluate work of child protective services (CPS);
- Ensures a **child is not required to be reunited with a parent** who has been convicted of certain crimes against a sibling of the child or the child;
- Requires **health care providers to notify CPS** when an infant is born affected by illegal substance abuse or withdrawal symptoms due to prenatal drug exposure, or fetal alcohol spectrum disorder;
- Refers victims of child abuse and neglect two years of age or younger to **early intervention services** (under Part C of IDEA); and
- Provides for "systems of technology" that support the State CPS and **track child abuse and neglect reports** from intake to final disposition.

Further, to the "maximum extent practicable" **the state must annually provide certain data** to HHS and must **describe training** provided for workers and mandatory reporters offered under the grant as well as **services** to individuals and families.



CRS-18

CAPTA Definitions

CHILD ABUSE AND NEGLECT

At a minimum, any recent act or failure to act *on the part of a parent or caretaker*, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

PARENT OR CARETAKER

As defined in state law.

CHILD

Under 18 years of age or, in the case of sexual abuse, the age specified in child protection law of the state where the child resides.

NEAR FATALITY

An act that, as certified by a physician, places the child in serious or critical condition.

SERIOUS BODILY INJURY

Bodily injury which involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ or mental faculty.



CRS-19

CAPTA Confidentiality Rules

Other federal confidentiality rules may also apply

Child abuse and neglect records must remain confidential to “protect the rights of the child and of the child’s parents or guardians.”

Who Must Have Access (and in what instances)?

- A federal, state, or local government entity (or agent) needing the information to carry out its duty under law to protect children from abuse and neglect.
- Citizen review panel (if the information is needed to carry out its function under CAPTA).
- Child fatality review panel (in child fatality or near fatality cases).

Who May Have Access?

- Individuals who are the subject of the report.
- A grand jury or court (upon a finding that the information is necessary for determination of issue before the court or jury).
- Other entities or classes of individuals authorized in state law to receive this information for a legitimate state purpose.

The public *must* be allowed access to findings or information of cases involving child fatality or near fatality.

A state *may* allow public access to court proceedings determining child abuse or neglect cases, so long as it can ensure the safety and well-being of the child, parents and families.



CRS-20

Citizen Review Panels

Citizen Review Panels will “provide new opportunities for citizens –not just child protection bureaucrats – to play an integral role in ensuring that states are meeting their goals of protecting children from abuse and neglect.”

- Rep. William Goodling, *Congressional Record*, September 25, 1996

States must –

- establish panels;
- provide case information as necessary;
- provide requested staff assistance;
- provide a written response to panel recommendations;
- submit panel reports to HHS annually.

Panels must –

- **evaluate whether state and local agencies are providing child protection** in accordance with CAPTA;
- be comprised of **volunteers broadly representative of community**;
- meet at least once every three months;
- provide for **public outreach** and comment;
- **maintain confidentiality of records** reviewed; and
- produce an **annual report** of their activities along with **recommendations** for CPS improvements.



CRS-21

Reporting Child Abuse and Neglect Fatalities, Child Maltreatment 2012

To the “maximum extent practicable” states must annually submit to HHS data on these items related to child deaths:

- The number of deaths in the state resulting from child abuse or neglect. **National estimate of 1,640 such deaths.**
- The number of those child deaths that were of children who were in foster care when they died of abuse or neglect. **Among 41 states reporting: four child deaths perpetrated by a foster care parent or group home/residential staff person.***
- The number of children receiving family preservation services that, within five years, resulted in a subsequent substantiated child abuse and neglect case, including the child’s death. **Among 30 states reporting: 75 such child deaths.**
- The number of children reunited with their families that, within five years, resulted in a subsequent substantiated child abuse and neglect case, including the child’s death. **Among 35 states reporting: 22 such child deaths.****

*This count, by perpetrator, is not necessarily equivalent to deaths in foster care.. For example, a child might die at the hand of a parent while still in foster care but on a trial home visit **Some, or all of these 22 deaths might also be counted in the 75 deaths among children in families received family preservation services.



CRS-22

CAPTA Discretionary Activities

FY2014 funding: \$29 million*

Required Activities:

- Support national clearinghouse on child abuse and neglect;
- Develop a federal data collection system on child abuse and neglect, compile and make available state-reported data;
- Compile, analyze and publish a summary of certain research conducted under CAPTA;
- Carry out a continuing inter-disciplinary program of research to better protect children from abuse and neglect and improve the well-being of victims of child abuse and neglect;
- Conduct research on the national incidence of child abuse and neglect;
- Conduct a study of shaken baby syndrome; and
- Provide certain technical assistance to state and local public and private organizations.

Allowed Activities:

- Establish an Office of Child Abuse and Neglect;
- Establish an Advisory Board on Child Abuse and Neglect;
- Support demonstration projects, programs and grants on wide range of relevant topics.

*The explanatory material accompanying the Consolidated Appropriations Act, 2014 (PL. 113-76) stipulates that of this sum, \$3 million is for "implementation of research-based court team models that include the court system, child welfare agency, and community organizations in order to better meet the needs of infants and toddlers in foster care."



CRS-23

Children's Justice Act Grants

FY2014 funding: \$17 million to states (HHS-Administered) \$3 million to tribes (DOJ-administered)

States must meet all requirements of CAPTA state grants and must establish a multi-disciplinary taskforce to review how the state handles civil and criminal child abuse and neglect cases.

Efforts are to focus on improving assessment, investigation, and/or prosecution of child abuse and neglect cases, particularly those involving suspected sexual abuse and exploitation of children, child fatalities suspected to be caused by abuse or neglect, and those involving children who are disabled and children with serious health disorders.

The program authority for these grants is included in CAPTA but they receive funding out of the Crime Victims Fund (based on a statutory set-aside language provided in the Victims of Crime Act)



CRS-24

Community-Based Grants to Prevent Child Abuse and Neglect (CBCAP)

Title II of CAPTA; FY2014 Funding: \$40 million

Grants to support community-based prevention efforts.

Funds are distributed to a lead entity in every state and that entity in turn must distribute funds to community based organizations that work to prevent child abuse and neglect through – parent education, mutual support, and self-help activities; provision of community and social service referrals; outreach services; voluntary home visiting; respite care; and support for public information campaigns to prevent child abuse or neglect.

- Services are for families /children who do not have open child welfare case.

Lead entity is often state child welfare agency but is sometimes Children's Trust Fund.



CRS-25

Stephanie Tubbs Jones Child Welfare Services Program (CWS)

Title IV-B, Subpart 1 (FY2014 funding: \$269 million).

PURPOSES: Promote state flexibility in development and expansion of a coordinated child and family service program that • protects and promotes the welfare of children; • **prevents the neglect, abuse or exploitation of children**; • supports at-risk families to allow children to remain safely in the home or return in a timely manner; • promotes safety, permanence, and well being of children in foster and adoptive families; and • provides training and professional development to ensure a well-qualified workforce.

- States required to have **pre-placement prevention services**; provide certain **protections for all children in foster care** (including case planning and case review); develop health oversight plan for all children in foster care; meet other requirements; and provide no less than 25% of program funds.
- The **largest single spending category under CWS is for child protection services**, including investigation and assessments as well as caseworker home visits for children living in their own homes or in foster care.
- In the 2011 reauthorization states were required to make efforts to improve reporting of child abuse and neglect related fatalities.



CRS-26

Promoting Safe and Stable Families Program (PSSF)

Title IV-B, Subpart 2, FY2014 funding - \$380 million

PURPOSES: Enable states to have coordinated program of services to **prevent child maltreatment; assure children's safety in the home;** address problems of families placed in foster care; support adoptive families.

To receive funds states must plan for a continuum of child and family services, set service goals and provide not less than 25% of program funds; and

- assure that the "safety of the children to be served shall be of paramount concern;"
- describe how they identify populations at greatest risk of maltreatment and target services to them.

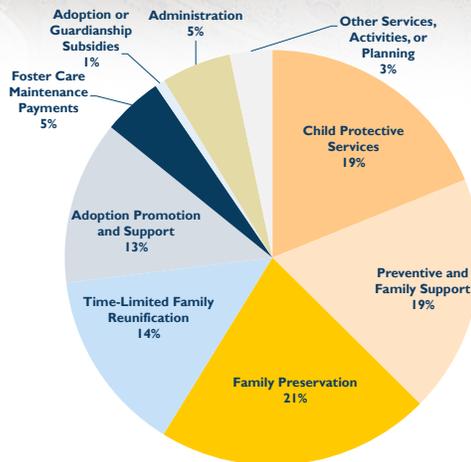
No less than 90% of funding must be used in four categories of services: family support, family preservation, time-limited family reunification; and adoption promotion and support.

Additional PSSF activities supported out of the overall funds for the program (*estimated* FY2014 set-aside amounts): Court Improvement Program - \$30 million; Monthly Caseworker Visits grants - \$19 million; and Regional Partnership Grants to Improve Outcomes for Children Affected by Parental Substance Abuse - \$19 million.



CRS-27

State Planned Spending of Federal Title IV-B Funds, FY2013



Based on states (50 states, DC and PR) reporting a total of \$590 million in planned expenditure of federal Title IV-B funding, including \$273 million in Child Welfare Services (Title IV-B, Subpart 1) spending and \$317 million in Promoting Safe and Stable Families (Title IV-B, Subpart 2) spending. Actual spending may vary based on final appropriation level and other factors.



Source: Figure prepared by the Congressional Research Service based HHS, ACFC, Children's Bureau, Report to Congress on State Child Welfare Expenditures, (Dec.2013), Attachments C and D.

CRS-28

The Title IV-E Program of the Social Security Act

The **Title IV-E program** entitles states to **federal reimbursement for a part of the cost** of providing:

- **FOSTER CARE** to each eligible child, including monthly assistance (maintenance payments), child placement and permanency planning casework, and related training, data collection and other program administration. FY2012 spending - \$8.055 billion, including \$4.208 billion in federal dollars and \$3.848 billion in state/local funds; 156,500 children received assistance in average month.
- **ADOPTION ASSISTANCE** to each eligible child with "special needs"; these are primarily children leaving foster care who cannot return to their biological parents and who state determines have a condition or factor (e.g., older age, part of a sibling group, disability) that means they are unlikely to be adopted without assistance. FY2012 total spending - \$4.104 billion, including \$2.278 billion in federal dollars and \$1.826 billion in state/local funds; 425,900 children received assistance in average month.
- **KINSHIP GUARDIANSHIP ASSISTANCE** to each eligible child who leaves foster care to live with a relative guardian; option established in FY2009. 31 states have implemented this option (including DC); as of FY2012, 27 had submitted claims. FY2012 total spending - \$127 million, including \$68 million in federal dollars and \$59 million in state/local funds; 16,000 children received assistance in an average month.

Note: The FY2012 Title IV-E spending shown here is based on state claims submitted to HHS for reimbursement. Because Title IV-E is an open-ended entitlement, the amount of claims made may not be identical to definite budget authority provided for a given year.



CRS-29

Title IV-E Program, Continued

To receive Title IV-E funds a state must have an approved Title IV-E plan under which it –

- provides foster care maintenance payments, adoption assistance, and (if state elects to provide this support) kinship guardianship assistance to each child meeting Title IV-E eligibility criteria;
- meets additional requirements, primarily related to protecting the safety and well-being of children in foster care; promoting their safe return home, or move to a new permanent family, as quickly as safe and appropriate; and
- submits quarterly "claims" for reimbursement of its eligible Title IV-E assistance, case work, training, data collection, and other administrative costs.

Title IV-E may not be used to support "services" (without a waiver).

Title IV-E program funding is authorized on a mandatory, open-ended, and "permanent" basis. States may claim partial reimbursement for costs they incur under their IV-E plan, generally, on behalf of children who meet the federal eligibility criteria.



CRS-30

Reasonable Efforts

States are required to make “reasonable efforts” to preserve families – to prevent children’s entry to foster care and, when children enter foster care to reunite them with their parents.

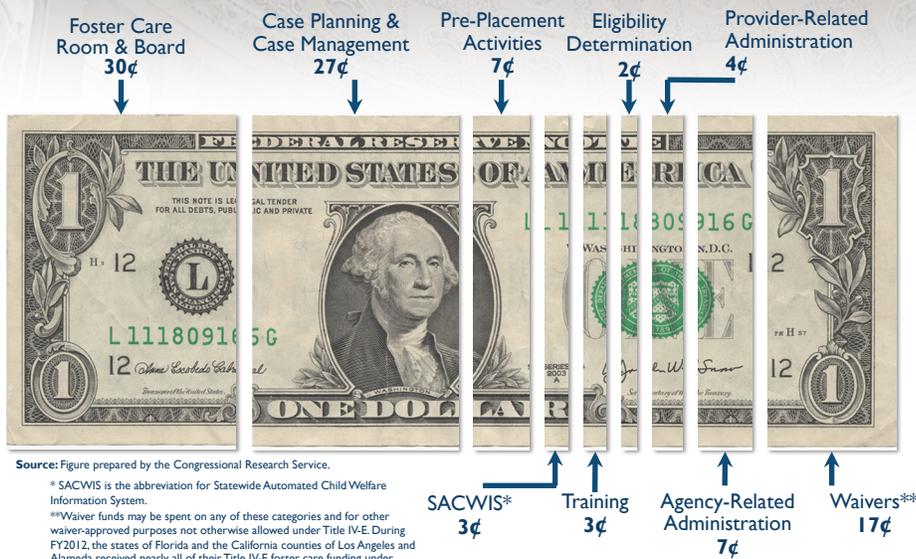
- In mid-1990s Congress grew concerned that courts were interpreting this requirement in a way that meant children could be unsafely reunited with parents or remain indefinitely in foster care.
- The Adoption and Safe Families Act of 1997 (ASFA) provided that states did not need to make reasonable efforts to reunite a parent with his/her child if the parent
 - had subjected the child to “aggravated circumstances,”
 - murdered or committed voluntary manslaughter of another child of the parent,
 - aided, abetted attempted, conspired or solicited such a murder or manslaughter,
 - committed felony assault that results in serious bodily injury to the child or another child of the parent, or
 - had his/her parental rights to a sibling of the child involuntarily terminated.
- Established expedited permanency planning/TPR efforts.



CRS-31

What Does a Title IV-E Foster Care Dollar Buy?

Total Claims for FY2012: \$8.055 billion, including federal share (\$4.208 billion) and state share (\$3.848 billion)

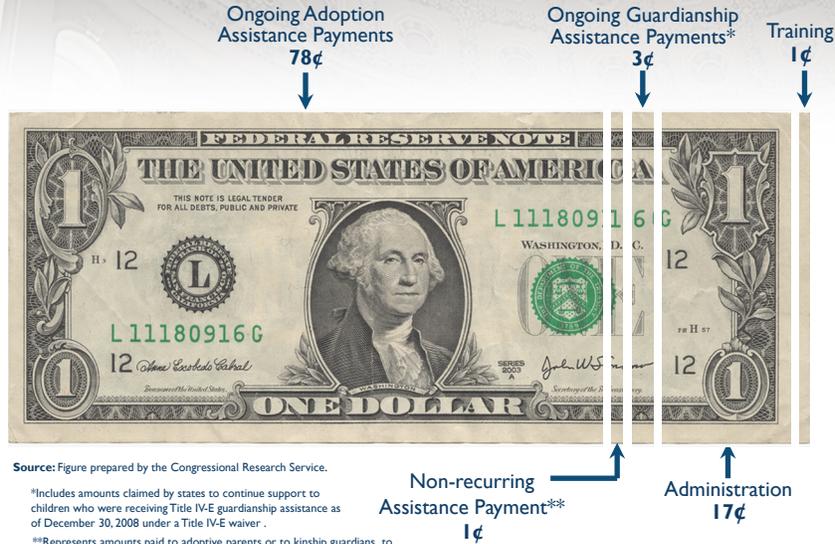


Source: Figure prepared by the Congressional Research Service.
 * SACWIS is the abbreviation for Statewide Automated Child Welfare Information System.
 **Waiver funds may be spent on any of these categories and for other waiver-approved purposes not otherwise allowed under Title IV-E. During FY2012, the states of Florida and the California counties of Los Angeles and Alameda received nearly all of their Title IV-E foster care funding under waivers and they spent 95% of the waiver funds represented here.

CRS-32

What Does a Title IV-E Permanency Dollar Buy?

Total Claims for FY2012: \$4.231 billion, including federal share (\$2.346 billion) and state share (\$1.885 billion)



Source: Figure prepared by the Congressional Research Service.

*Includes amounts claimed by states to continue support to children who were receiving Title IV-E guardianship assistance as of December 30, 2008 under a Title IV-E waiver.

**Represents amounts paid to adoptive parents or to kinship guardians to offset the cost of finalizing an adoption or establishing a legal guardianship.

CRS-33

General Purpose Grants and Medicaid



CRS-34

Temporary Assistance for Needy Families (TANF) Title IV-A of the Social Security Act

Total FY2014 federal funding: \$17.3 billion.

- TANF is a block grant; it replaced AFDC in 1996.
- Federal administration: HHS, ACF, Office of Family Assistance.

PURPOSES: Increase flexibility of state in operating a program to–

- 1) **provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;**
 - 2) end dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
 - 3) prevent and reduce the incidence of out-of-wedlock pregnancies; and
 - 4) encourage the formation and maintenance of two-parent families.
- TANF may also be used to support activities authorized under prior law in the Emergency Assistance program.
 - Up to 10% of state's TANF grant may be shifted to the Social Services Block Grants (SSBG).



CRS-35

Social Services Block Grant (SSBG)

Title XX of the Social Security Act

Total FY2014 funding: \$1.7 billion.

- Earliest program roots are in social services funding authorized earlier under the AFDC (Title IV) program.
- Federal Administration: HHS, ACF, Office of Community Services.

PURPOSES: Increase state flexibility in using social service grants and to encourage each state to provide services directed at goals of –

- achieving or maintaining economic self-support or self sufficiency to prevent, reduce, and/or eliminate dependency;
- **preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;**
- preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.



CRS-36

Medicaid (Title XIX of the Social Security Act)

*Total federal funding FY2014: \$308 billion**

- Originally medical assistance for cash aid recipients
- Federal Administration: HHS, Centers for Medicare and Medicaid Services (CMS)

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports, for a diverse low-income population, including children, pregnant women, adults, individuals with chronic disabling conditions, and people age 65 and older

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) is a required benefit for nearly all children (up to age 21) who are Medicaid beneficiaries. EPSDT covers health screenings and services, including assessments of each child's physical and mental health development; laboratory tests (including lead blood level assessment); appropriate immunizations; health education; and vision, dental, and hearing services.



*Based on net federal obligations as shown for FY2014 in the FY2015 CMS budget justification.

CRS-37

Program Relationships



CRS-38

Program Administration and Categorical Eligibility

Must be administered by the same state agency

- Social Services Block Grant (SSBG)(Title XX)
- Child Welfare Services (CWS, Title IV-B, Subpart 1)
- Promoting Safe and Stable Families (PSSF, Title IV-B, Subpart 2)
- Foster Care, Adoption and Kinship Guardianship Assistance (Title IV-E)

Categorical Eligibility

Children who are eligible for Title IV-E assistance must be eligible for Medicaid (Title XIX)



CRS-39

Coordination

Services provided for children under CWS must be coordinated with services and assistance provided under SSBG, Temporary Assistance for Needy Families (TANF, Title IV-A), and PSSF, as well as any related state programs "with a view to provision of welfare and related services which will best promote the welfare of such children and their families."

Programs at the local level assisted by Title IV-E must be coordinated with programs at the state or local level assisted under TANF, CWS, PSSF and SSBG and any other appropriate provision of federal law.



CRS-40

Assurances

Under **CAPTA state grants**, state must assure that

- to the “maximum extent practicable,” the CAPTA state plan is coordinated with CWS and PSSF plans related to child welfare services and family preservation and family support services; and
- programs and projects related to child abuse and neglect carried out under CWS and PSSF (both Title IV-B) comply with CAPTA requirements.

TANF state plan must assure that

- the state will operate a foster care and adoption assistance program under Title IV-E
- the state will take such actions as are necessary to ensure that children receiving IV-E assistance are eligible for Medicaid (Title XIX).



CRS-41

Additional Programs of Interest



CRS-42

Additional Programs of Interest

Maternal and Child Health Block Grant (Title V of the Social Security Act); FY2014 funding - \$634 million. Funds to state public health agencies to improve the health of all mothers and children, including by reducing infant mortality.

Maternal Infant and Early Childhood Home Visiting (MIECHV) Title V (Sec. 511) of the Social Security Act; FY2014 federal funding - \$371 million. Funds to lead agency in each state to support evidence-based home visiting programs to reduce child abuse, neglect, and injuries, and to improve maternal and child health, child development, parenting related to child development outcomes, school readiness, and the socioeconomic status of families.

Infants and Toddlers with Disabilities (Part C of the Individuals with Disabilities Education Act, IDEA) – FY2014 funding - \$439 million. Funds to state agency to support early intervention services for children with disabilities or developmental delays who are under age 3, including an individualized family service plan.



CRS-43

Additional Programs of Interest, continued

Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Section 17 of the Child Nutrition Act; FY2014 funding: \$6.7 billion. Funds to eligible local agencies to provide supplemental food and nutrition education for low-income pregnant or breastfeeding women and their children (under age 5).

Family Violence Prevention and Services Act (FVPSA), FY2014 funding \$143 million. Primarily provides funds to all states to support domestic violence shelters and support services; also supports the national domestic violence hotline, and domestic violence prevention activities (under the DELTA program).

Edward Byrne Memorial Justice Assistance Grant Program (JAG), FY2014 funding: \$376 million. Funds to state and local governments to support law enforcement and related activities, including (among others) programs related to courts and prosecution, prevention and education, drug treatment, services for crime victims and witnesses (other than compensation).



CRS-44

Additional Programs of Interest, continued

Substance Abuse Prevention and Treatment Block Grant

(SABG) – Public Health Service Act, Sec. 1921; FY2014 funding: \$1.7 billion. Funds to states to plan, carry out, and evaluate substance abuse prevention, treatment and recovery support services.

Community Mental Health Services Block Grant (MHBG) –

Public Health Service Act, Sec. 1911. Funds to states to support services and for planning, administration, and educational activities under the state plan for comprehensive community-based mental health services for children with serious emotional disturbance and adults with serious mental illness.



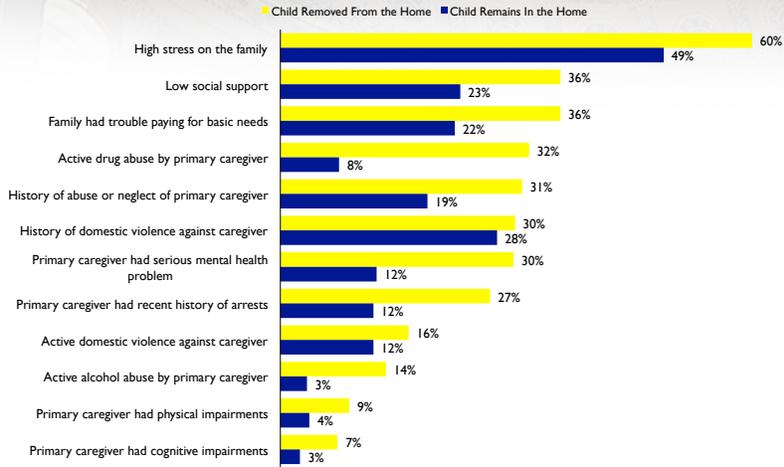
CRS-45

Children and Families Coming into Contact with Child Welfare



CRS-46

Selected Risk Factors Associated with Families Investigated for Child Abuse and Neglect

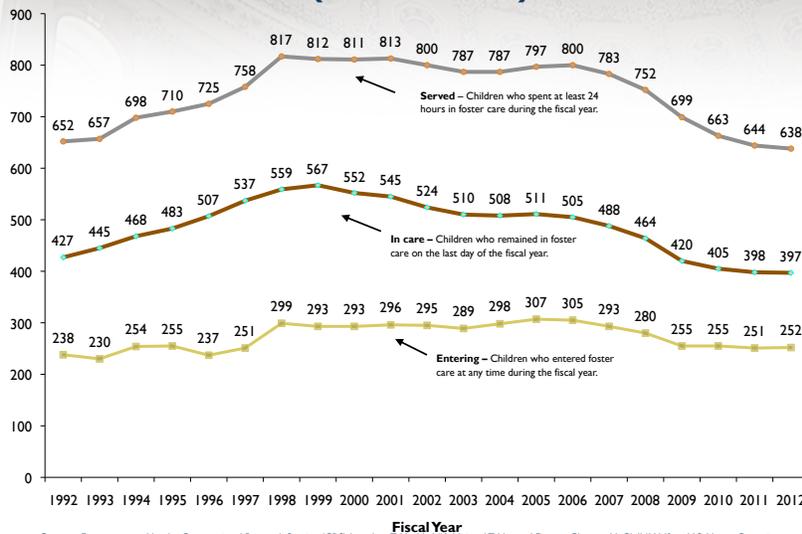


Source: Table prepared by the Congressional Research Service based on tabulations of National Survey of Child and Adolescent Wellbeing (NSCAW) II baseline data received from HHS, ACF, Office of Planning Research and Evaluation (OPRE).

Notes: NSCAW II is a national survey of more than 5,000 children in families that were investigated for child abuse or neglect between February 2008 and April 2009. Where children live is shown as of four months after the investigation. Risk factors are as assessed by the investigative caseworker.

CRS-47

Children Served, Entering, or in Foster Care, FY1990-FY2012 (in thousands)



Source: Figure prepared by the Congressional Research Service (CRS) based on Table 11-4, "Additional Tables and Figures, Chapter 11-Child Welfare, U.S. House Committee on Ways and Means, 2012 Green Book, and HHS, ACF, "Trends in Foster Care and Adoption," state data reported as of Nov. 1, 2013.

CRS-48



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CRS-49

COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES



Senator Carlos Uresti

Texas Senate District 19

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#CarlosUresti



District 19 Facts

- 800,000 people in 17 counties
- ½ of the Texas/Mexico border—Over 400 miles
- 55 school districts
- 10 State Parks and 3 National Parks
- 23,000 oil and gas wells (Growing daily)
- 2,700 miles of highway
- Home to Sul Ross State Univ. and TX A&M San Antonio
- 35,000 Sq./Miles. > 12 states, 82 countries & 2 planets!

Texas Facts

- Last fiscal year in Texas 156 children lost their lives to abuse or neglect, and over 66,000 were victims of abuse or neglect.
- 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, perpetuating the cycle of violence
 - 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 like to commit violent crime

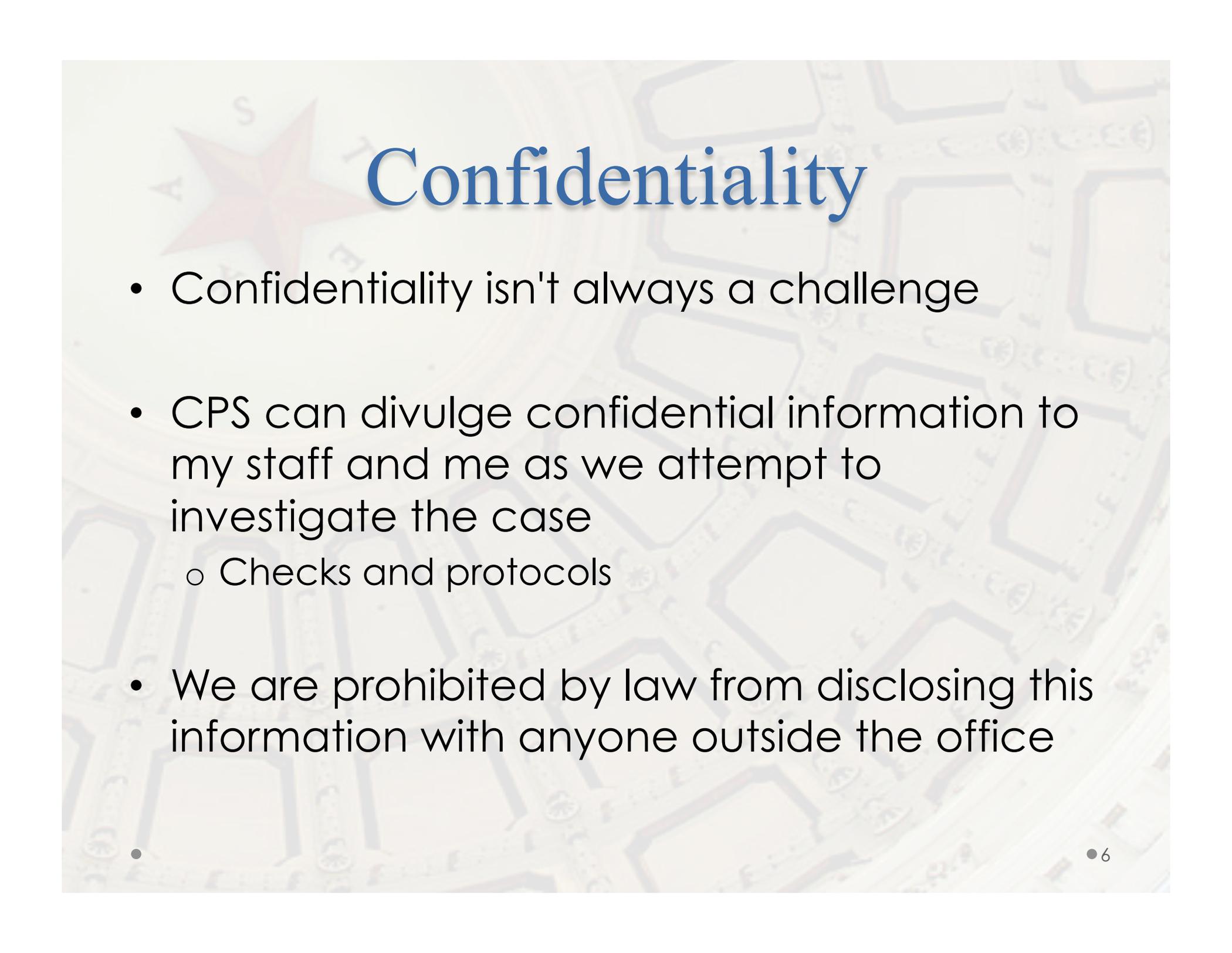
Prevention & Advocacy Work

- Home Visitation Programs
 - Nurse-Family Partnership (NFP)
 - "Parents as Teachers"
 - "AVANCE"
- Wrap-around Services
 - Senate Bill 769 (2013)
- Bexar County Blue Ribbon Task Force
 - SB 2080 (2009)
 - SB 1154 (2011)

Problems & Answers

- State's Decline in monetary investment
- Answer: Work with non-profits, faith based organizations, charitable foundations, and federal matching programs

- Caseworker Turnover
 - In 2013 over 1,300 CPS caseworkers left their jobs because of poor working environment, long hours, high caseloads, and unsupportive supervisors being the main factors
- Answer: SB 771 (2013)



Confidentiality

- Confidentiality isn't always a challenge
- CPS can divulge confidential information to my staff and me as we attempt to investigate the case
 - Checks and protocols
- We are prohibited by law from disclosing this information with anyone outside the office

Thank you!

Senator Carlos Uresti

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